

2018

The Unofficial MMPI-2 Supermanual

A SUPPLEMENTAL FOR THE ASPIRING PSYCHOLOGIST

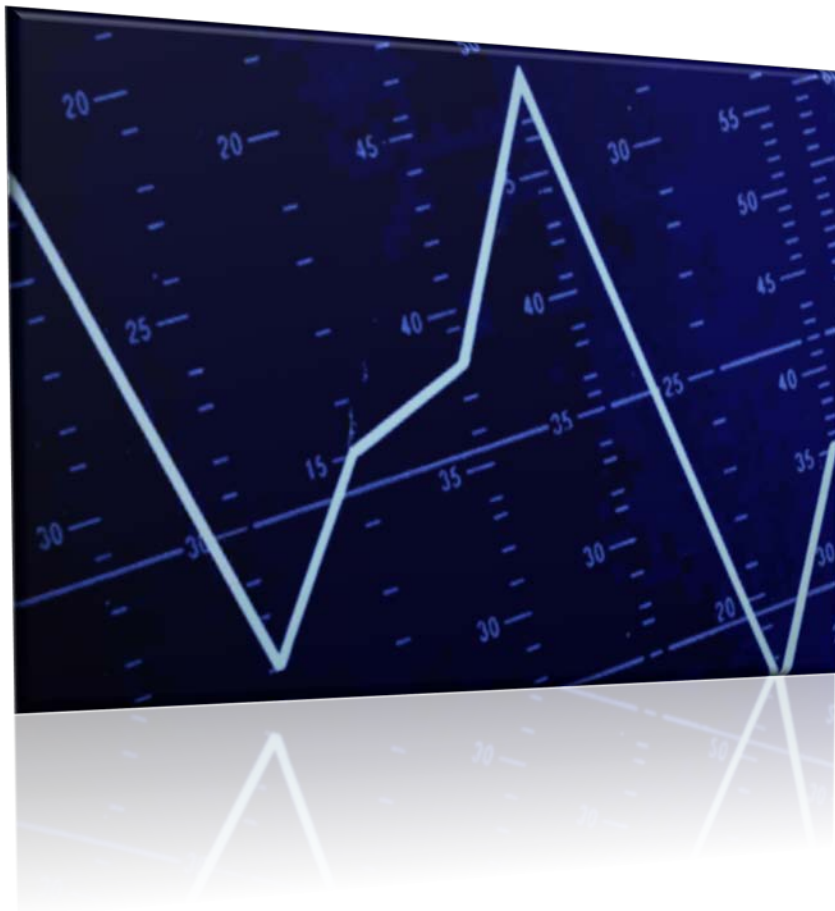
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The Unofficial MMPI-2 Supermanual

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A message from the Compiler:



This is a handy guide for psychology students to understand the MMPI-2 – In this “manual” you will find everything you need to administer, score and interpret the entire test. Obviously, I will not be providing contact information, but those of you wishing to learn more should simply grab any chunk of text and search Google for the source; most information has been taken from sources on www.Archive.org and www.libgen.io.

It is important to understand this is not a published textbook, and as such cannot be cited for use in any official setting. All of the information below is in lieu of copyright laws. I must stress again, use this manual however you wish but do not let it fall into the hands of any authority figure, as I enjoy my freedom. Just consider yourself lucky you have this.

And if you are indeed an authority figure, let me first say, this is an art project for entertainment purposes only.



THERAPEUTIC HISTORY FORM	12
INTRODUCING THE TEST.....	20
AUTOMATED SCORING PROGRAM	23
VALIDITY SCALES.....	23
? CANNOT SAY	23
L – LYING	24
F – INFREQUENCY	30
K – DEFENSIVENESS	40
F-K – DISSIMULATION INDEX.....	49
TRIN.....	50
VRIN	50
THE S SCALE	51
CLINICAL SCALES	54
01 – Hs – <i>HYPPOCHONDRIASIS</i>	55
02 – D – <i>DEPRESSION</i>	62
SUBJECTIVE DEPRESSION (D1)	72
PSYCHOMOTOR RETARDATION (D2)	74
PHYSICAL MALFUNCTIONING (D3)	75
MENTAL DULLNESS (D4)	77
BROODING (D5).....	78
SCALE 2: SUBTLE–OBVIOUS SUBSCALES	79
03 – HY – <i>HYSTERIA</i>	84
DENIAL OF SOCIAL ANXIETY (HY1).....	96

NEED FOR AFFECTION (HY2)	97
LASSITUDE MALAISE (HY3)	99
SOMATIC COMPLAINTS (HY4).....	101
INHIBITION OF AGGRESSION (HY5)	103
SCALE 3: SUBTLE—OBVIOUS SUBSCALES	104
04 – PD – <i>PSYCHOPATHIC DEVIANCE</i>	106
FAMILIAL DISCORD (PD1)	112
AUTHORITY PROBLEMS (PD2)	114
SOCIAL IMPERTURBABILITY (PD3).....	115
SOCIAL ALIENATION (PD4)	117
SELF-ALIENATION (PD5).....	119
SCALE 4: SUBTLE—OBVIOUS SUBSCALES	121
05 – MF – <i>MASCULINE-FEMININE</i>.....	123
06 – PA – <i>PARANOIA</i>.....	133
PERSECUTORY IDEAS (PA1)	135
POIGNANCY (PA2)	138
NAIVETÉ' (PA3)	139
SCALE 6: SUBTLE—OBVIOUS SUBSCALES	141
07 – PT – <i>PSYCHOSTHENIA</i>.....	144
08 – SC – <i>SCHIZOPHRENIA</i>.....	147
SOCIAL ALIENATION (Sc1)	149
EMOTIONAL ALIENATION (Sc2)	152
LACK OF EGO MASTERY, COGNITIVE (Sc3)	154
LACK OF EGO MASTERY, CONATIVE (Sc4)	156
LACK OF EGO MASTERY, DEFECTIVE INHIBITION (Sc5).....	158
BIZARRE SENSORY EXPERIENCES (Sc6)	161
09 – MA – <i>HYPOMANIA</i>.....	163
AMORALITY (MA1).....	167
PSYCHOMOTOR ACCELERATION (MA2)	169
IMPERTURBABILITY (MA3)	171
EGO INFLATION (MA4).....	173
SCALE 9: SUBTLE—OBVIOUS SUBSCALES	175
00 – SI – <i>SOCIAL INTROVERSION</i>.....	178
SHYNESS/SELF-CONSCIOUSNESS (SI1).....	187
SOCIAL AVOIDANCE (SI2).....	188
ALIENATION—SELF AND OTHERS (SI3)	188
<u>CODETYPES</u>	<u>189</u>
SPIKE 1	192
12/21 CODES.....	206
13/31 CODES.....	240
14/41 CODES.....	277

15/51 CODES.....	285
16/61 CODES.....	289
17/71 CODES.....	293
18/81 CODES.....	297
<i>19/91 CODES.....</i>	<i>303</i>
10/01 CODES.....	307
SPIKE 2	309
SPIKE 2, LOW 9 CODE	319
21/12 CODE	320
23/32 CODE	325
24/42 CODES.....	352
25/52 CODES.....	407
26/62 CODES.....	416
27/72 CODES.....	431
28/82 CODES.....	487
29/92 CODES.....	513
20/02 CODES.....	530
SPIKE 3	541
SPIKE 3, HIGH K CODE	552
31/13 CODE	553
32/23 CODE	559
34/43 CODES.....	567
35/53 CODES.....	594
36/63 CODES.....	600
37/73 CODES.....	615
38/83 CODES.....	629
39/93 CODES.....	645
30/03 CODES.....	658
SPIKE 4	660
HIGH 4, LOW 5 CODE	672
41/14 CODES.....	673
42/24 CODES.....	673
43/34 CODES.....	675
45/54 CODES.....	676
46/64 CODES.....	684
47/74 CODES.....	716
48/84 CODES.....	733
49/94 CODES.....	772
40/04 CODES.....	801
SPIKE 5 [MALE]	803

SPIKE 5 [FEMALE].....	813
5? CODE.....	823
53 CODE.....	824
54 CODE.....	824
56/65 CODES.....	824
57/75 CODES.....	830
58/85 CODES.....	834
59/95 CODES.....	838
50/05 CODES.....	841
SPIKE 6	843
61/16 CODES.....	854
62/26 CODES.....	854
63/36 CODES.....	854
64/46 CODES.....	855
65/56 CODES.....	855
67/76 CODES.....	855
68/86 CODES.....	862
69/96 CODES.....	877
60/06 CODES.....	892
SPIKE 7	895
71/17 CODES.....	907
72/27 CODES.....	907
73/37 CODES.....	907
74/47 CODES.....	907
75/57 CODES.....	908
76/67 CODES.....	908
78/87 CODES.....	908
79/97 CODES.....	928
70/07 CODES.....	932
SPIKE 8	935
81/18 CODES.....	946
82/28 CODES.....	947
83/38 CODES.....	947
84/48 CODES.....	951
85/58 CODES.....	951
86/68 CODES.....	951
87/78 CODES.....	956
89/98 CODES.....	957
80/08 CODES.....	977
SPIKE 9	980

91/19 CODES.....	994
92/29 CODES.....	994
93/39 CODES.....	995
94/49 CODES.....	996
95/59 CODES.....	996
96/69 CODES.....	996
97/79 CODES.....	1000
98/89 CODES.....	1000
90/09 CODES.....	1001
SPIKE 0 (SI)	1003
01/10 CODES.....	1013
02/20 CODES.....	1017
03/30 CODES.....	1024
04/40 CODES.....	1028
05/50 CODES.....	1033
06/60 CODES.....	1036
07/70 CODES.....	1039
08/80 CODES.....	1042
09/90 CODES.....	1044
LOW 0.....	1045
NORMAL CODE, HIGH K (K+).....	1045

CONTENT SCALES1046

ANX—ANXIETY	1053
FRS—FEARS	1055
GENERALIZED FEARFULNESS FRS1.....	1056
MULTIPLE FEARS FRS2.....	1057
OBS—OBSESSIVENESS	1059
DEP—DEPRESSION	1063
LACK OF DRIVE DEP1.....	1064
DYSPHORIA DEP2	1065
SELF-DEPRECIATION DEP3	1065
SUICIDAL IDEATION DEP4.....	1065
HEA—HEALTH CONCERNS	1068
GASTROINTESTINAL SYMPTOMS HEA1	1070
NEUROLOGICAL SYMPTOMS HEA2.....	1070
GENERAL HEALTH CONCERNS HEA3.....	1070
BIZ—BIZARRE MENTATION	1071
PSYCHOTIC SYMPTOMATOLOGY BIZ1	1072
SCHIZOTYPAL CHARACTERISTICS BIZ2	1072
ANG—ANGER	1074

EXPLOSIVE BEHAVIOR ANG1.....	1077
IRRITABILITY ANG2	1077
CYN--CYNICISM.....	1079
MISANTHROPIC BELIEFS CYN1	1082
INTERPERSONAL SUSPICIOUSNESS CYN2	1082
ASP--ANTISOCIAL PRACTICES	1084
ANTISOCIAL ATTITUDES ASP1	1085
ANTISOCIAL BEHAVIOR ASP2	1086
TPA--TYPE A	1088
IMPATIENCE TPA1.....	1090
COMPETITIVE DRIVE TPA2.....	1091
LSE--LOW SELF-ESTEEM	1093
SELF-DOUBT LSE1.....	1095
SUBMISSIVENESS LSE2	1095
SOD--SOCIAL DISCOMFORT	1097
INTROVERSION SOD1	1098
SHYNESS SOD2.....	1098
FAM--FAMILY PROBLEMS	1101
FAMILY DISCORD FAM1.....	1104
FAMILIAL ALIENATION FAM2	1105
WRK--WORK INTERFERENCE	1106
TRT--NEGATIVE TREATMENT INDICATORS	1110
LOW MOTIVATION TRT1.....	1112
INABILITY TO DISCLOSE TRT2	1113
 SUPPLEMENTARY SCALES.....	 1115

ES--EGO STRENGTH.....	1123
MAC-R--MACANDREW ALCOHOLISM-REVISED SCALE.....	1136
APS--ADDICTION POTENTIAL SCALE	1151
AAS--ADDICTION ACKNOWLEDGMENT SCALE.....	1153
A--ANXIETY SCALE.....	1154
R--REPRESSION SCALE	1168
O-H--OVERCONTROLLED HOSTILITY	1177
DO--DOMINANCE SCALE	1181
RE--SOCIAL RESPONSIBILITY SCALE	1187
MT--COLLEGE MALADJUSTMENT.....	1198
PK--POST TRAUMATIC STRESS DISORDER SCALE	1205
PS--POST TRAUMATIC STRESS DISORDER SCALE	1206
GM--MASCULINE GENDER ROLE AND GF--FEMININE GENDER ROLE	1207
MDS - MARITAL DISTRESS SCALE	1213
HO - HOSTILITY SCALE	1215

PSY-5 SCALES	1219
AGGR (AGGRESSIVENESS)	1223
PSYC (PSYCHOTICISM)	1228
DISC (DISCONSTRAINT)	1232
NEGE (NEGATIVE EMOTIONALITY/NEUROTICISM)	1237
INTR (INTROVERSION/LOW POSITIVE EMOTIONALITY)	1239
HARRIS-LINGOES SCALES	1243
RESTRUCTURED CLINICAL (RC) SCALES	1247
DEMORALIZATION (RCd)	1247
SOMATIC COMPLAINTS (RC1)	1249
LOW POSITIVE EMOTIONS (RC2)	1250
CYNICISM (RC3)	1252
ANTISOCIAL BEHAVIOR (RC4)	1253
IDEAS OF PERSECUTION (RC6).....	1255
DYSFUNCTIONAL NEGATIVE EMOTIONS (RC7)	1257
ABERRANT EXPERIENCES (RC8)	1259
HYPOMANIC ACTIVATION (RC9).....	1261
THE CRITICAL ITEM APPROACH.....	1263
THE KOSS—BUTCHER CRITICAL ITEM LIST	1264
THE LACHAR—WROBEL CRITICAL ITEM LIST	1265
USE OF CRITICAL ITEMS	1265
WELSCH CODE.....	1265
THE NEXT STEP.....	1265
DSM AND AXIS 1 CONDITIONS.....	1265
FEELS CARED FOR/LOVED VS. NEGLECTED/DISLIKED.....	1266
AUTONOMOUS/SELF-POSSESSED VS. SELF -DOUBTING/SHAMED	1268
INITIATING/PURSUIING VS. REGRETFUL/GUILT-PRONE	1270
INDUSTRIOUS/CAPABLE VS. INADEQUATE/INFERIOR.....	1272
LIFE-GOAL ORIENTED/EGO IDENTITY SECURE VS. DIRECTIONLESS/CONFUSED	1273
SOCIALLY COMMITTED/INVOLVED VS. DISENGAGED/LONELY	1274
PSYCHOSOCIAL SCALES, CONTENT CLUSTERS, AND AXIS I CONDITIONS.....	1275
ANALYSES OF PRESENCE VS. ABSENCE OF DIFFICULTIES	1277
REFERENCES	1282

SCALE COMPOSITION	1282
VALIDITY AND CLINICAL SCALES	1282
RESEARCH SCALES.....	1287
SCORING SHEETS.....	1297

Therapeutic History Form

Introduction

I would like to get to know you and to understand your story. I am not looking for problems as much as wanting to know about you and the events that have shaped you.

Name _____

Age _____

Marital status S W D M P (Partner) Are you in a current relationship?

Yes / No

Occupation? _____

How long have you been in your present job? _____

Do you enjoy it?

Yes / No

Why? _____

Children: Yes / No If yes, number of children: Sons Age(s) _____ Daughters Age(s) _____

How are they doing: At school, in peer relationships? _____

Family History

Place of birth _____ Where did you grow up? _____

Chronology and explanation of moves: _____

(Explore the possible effects of moves and subsequent adaptation and resilience shown or possible negative but understandable reactions that could promote clients' self-knowledge and empathy.)

Number of siblings _____

Brothers _____ Sisters _____ Stepbrothers _____ Stepsisters _____

Half-brothers _____ Half-sisters _____

What is the "story" of the various step- or half-siblings? _____

Are you the Oldest _____ Middle _____ Youngest _____

What was this like? _____

(This is an opportunity to inquire about and validate experiences associated with birth order.)

Your father's profession? _____

(Some professions are more likely to be associated with uncertainty or financial insecurity—for example, the work of a migrant farm worker versus the medical profession.)

What kind of person is/was your dad when you were growing up, though he may have changed later?

Warm _____ Present _____ Absent _____ Strict _____ Overprotective _____

Cruel _____ Playful _____ Alcoholic _____ Mentally ill _____ Other _____

(This provides the therapist with an opportunity to validate and explore childhood conditioning experiences that could explain MMPI-2 code-type data—for example, a 4-8 code type with a history of paternal rejection)

and cruelty.)

Your mother's profession? _____

What kind of a person was your mother when you were growing up?

Traditional mom _____ Warm _____ Present _____ Absent _____ Strict _____

Overprotective _____ Cruel _____ Mentally ill _____ Alcoholic _____

(This provides the therapist with an opportunity to validate and explore childhood conditioning experiences that could explain MMPI-2 code-type data—for example, a 2-8 code type with a history of maternal rejection and withdrawal.)

Did either of your parents have problems with:

Drugs _____ Alcohol _____ What kinds of alcohol or drug problems?

Quiet drunk/embarrassing drunk _____; raging/hostile drunk? _____

(Explore possible painful traumatic conditioning experiences associated with parental substance abuse, and validate possible sequelae. Look for examples of resilience, like hyperresponsibility [e.g., child taking care of parents] or the development of emotional numbness to deal with trauma.)

Any family history of mental illness (e.g., depression, suicide attempts, anxiety symptoms)?

Yes / No

(What were the clients' experiences of that illness? Validate the client's reactions where relevant, and look for early conditioning that could be congruent with a particular code type, such as a client with a mentally ill parent whose MMPI-2 profile reveals a 2-7 configuration suggesting a lifelong pattern of hyperresponsibility.)

Are your parents still living?

Yes / No

If not what did they die of? _____

How old were you when they died? _____

Are/were your parents together or divorced _____

If divorced, your age at their divorce? _____

(Examine the clients' experience of the divorce: did they feel responsible, caught in the middle? Any examples of resilience or signature strengths they used to cope?)

What is/was your parent's relationship like? (e.g., warm, loving, volatile, hateful) _____

(Explore possible conditioned reactions associated with the marital dynamics, such as clients become role players attempting to please both parents but also learning to selectively report and prevaricate. The MMPI-2 may, for example, later reveal a 3-4 code type, which may be associated with this early conditioning event.)

If either parent remarried, did you get along with the stepfamily?

Yes ____ No ____ N/A ____

(Examine possible adjustments to new family dynamics, and look for any adaptive resilience demonstrated in incorporating new family members, such as clients who become close to a stepparent and use that relationship as a source of mentoring.)

Childhood

Growing up, what was life in your family like before the age of 14 or 15?

If I were making a movie of your life in that early part, give me the set.

What kind of neighborhood did you live in? _____

Were you poor/well off/middle class? _____

Growing up, were finances OK?

Yes / No

(Look for opportunities to validate experiences associated with various levels of financial security. Experiences of extreme poverty or physical danger might be associated with various code types.)

What kind of kid were you before the age of 14?

Indoor ____ Outdoor ____ Popular ____ Quiet ____ Mischievous ____

Rebellious ____ Hyperactive ____ Insecure ____

(Typically, childhood and adolescent personality characteristics stay somewhat stable over the life span, so the personality as described by the MMPI-2 code type should be congruent with the personality as described by the client unless modified by trauma or other circumstances.)

What kind of student were you in grade school? A/B , B/C , C/D , D/F

Adolescence

What were you like in adolescence (ages 14–18)?

Popular ____ Rebellious ____ Athletic ____ Social ____

Studious Dating? ____ Drugs? ____ Alcohol? ____ Friends? ____

What were your grades like?

Did you fall in love? Yes / No If yes, what was he/she like? _____

When was your first sexual experience? Positive? _____ Negative? _____

(Negative experiences may be associated with later dysfunction or may have successfully resolved.)

Were you ever in trouble in high school? Yes _____ No _____

Truant _____ Violence _____ Running away _____ Car theft _____ Shoplifting Arrests _____

(Look for opportunities to validate any signature strengths the clients exhibited so that these can be incorporated into individualized therapy suggestions.)

Adulthood

Did you graduate from high school? _____

What did you do after graduating from high school?

College?

Yes / No

What was college like? Describe your experience there: _____

(Some people, free from parental restriction, thrive, whereas others experience difficulty with the responsibility of emancipation.)

Relationships? _____

(Some individuals continue patterns of relationship—positive or negative—established in high school. Others learn and mature in their object choice.)

What happened after college? Keep going with your story, telling me the important events that shaped you (relationships, successes, traumas, milestones).

What has been the worst experience of your life? _____

(This is an opportunity to marvel at the fact that “in spite” of such adversity clients have shown some degree of resilience by getting through it and also provides a chance to empathize with the understandable pain and sequelae. Ask them what helped most, lessons learned, and so forth.)

What is your greatest accomplishment? _____

(This may give you ideas about their signature strengths and resources.)

Medical and Psychiatric History

Have you ever been involved in a major accident or trauma? Yes / No

(Acknowledge their emotion and the difficulty in the retelling of any trauma. Spend some time helping them gain a sense of empathy for themselves, and reinforce their courage in telling the story. Consider how the trauma may have reactivated any emotional scar tissue of early childhood events.)

Any head injury? Yes / No

Any loss of consciousness? Yes / No

Have you ever received psychiatric or psychological treatment or counseling? Yes / No

If yes, describe your experience: _____

Have you ever had any symptoms of depression or experienced serious sleep or appetite difficulties? Yes / No

If yes, describe your experience: _____

Have you ever had any symptoms of anxiety? Yes / No

Have you ever had a panic attack? Yes / No

If yes, describe your experience: _____

Are you currently or have you in the past taken medication for these or other emotional problems?

Yes / No

Have you ever felt so hopeless and discouraged that it was a struggle to just simply keep going? Yes / No

Did you ever consider suicide or have you ever attempted suicide? Yes / No

Have you ever had an eating disorder? Yes / No

Any medical problems or concerns? _____

How do you sleep currently? _____

Difficulty falling asleep, staying asleep, or waking up? _____

How is your memory and concentration? _____

How is your mood? _____

Drug and Alcohol History

How much alcohol do you drink each week? _____

What drugs have you experimented with (e.g., marijuana, cocaine, speed)?

Do you currently use? If yes, how much or how often? _____

At the conclusion of the history gathering, acknowledge the trust it takes for clients to tell their story, and thank them for being open and forthcoming. It may be wise to take a break or even schedule the testing for another day to give clients some time to process their experience of the therapeutic history.

Introducing the Test

Properly introducing the MMPI-2 can minimize defensiveness. Clients should be informed about the nature and purpose of taking the MMPI-2 and should be given an honest and clear indication of how the results will be used. It is useful to explain that after completing the test, once it is scored, clients will participate in a collaborative discussion of the results; if any feedback doesn't feel or sound "just right," the client and psychologist will act as a team to hone the interpretation. Consensus may not be possible in some situations but ought to be a goal whenever possible. Allowing clients to record the session or take notes affirms a collaborative, transparent relationship.

Sometimes roles can become murky, with negative consequences. Consider the following scenario given by Pope (1992). A therapist was asked to assess a client by a colleague. When the client returned to the next therapy session enthusiastic about how helpful the feedback was, the referring therapist became enraged; it was the referring therapist's intention to use the report to provide feedback to the client. This is one instance of the pitfalls that can occur, so despite the description of the goals of the assessment and the nature of the relationship in the informed

consent it is prudent to spend time discussing the details with all parties involved. Once the nature of the relationship has been addressed, the therapist can go over the test materials and can explain how best to complete the test.

We have found the following statements useful as a way to introduce people to the MMPI-2:

The MMPI-2 stands for the Minnesota Multiphasic Personality Inventory, Second Edition. It is a long name, but it is essentially a personality measure developed in Minnesota in the 1940s and extensively modernized. An advantage of the test being around so long is that it is widely researched and is the most widely used personality test in the world.

The MMPI-2 is used in a variety of settings with many different types of people. The purpose for you taking the test today is .

There are 567 items, all to be answered true or false. It typically takes people about 1 to 2 hours to complete the test. You can take as long as you need because people vary a great deal in the time they take to complete the test. You are free to stretch and take short breaks as needed. It's important that you feel comfortable and not distracted, so if at any time you need a break or find the conditions uncomfortable tell the person available.

It is important for you to be open and honest with your answers for us to understand you well. Your focus and attention are important as you answer the questions. It is helpful if you double-check at the end of each row to make sure you are on the correct question and have not lost your place.

Answer according to your current feelings and experiences, and answer what you feel is true about yourself.

Even though some questions may appear to not apply to you, answer every question, as omitting questions might distort our ability to understand you accurately. If you don't feel strongly either way about an item, answer whether it *mostly* true or *mostly* false. Answer all items. Please also note any questions you have difficulty answering or find confusing or irritating, and we will discuss them after you have completed the test.

Remember that the feedback session is a two-way process, so you will be actively involved in helping me understand you. If the test results don't describe you accurately or are not helpful, you will have a chance to clarify how you see yourself. We have asked you to take this test because it will help us understand you more fully and in less time. It will provide a road map and a beginning point to explore how you feel and what kinds of events may have shaped you.

There are a large number of questions because the test is flexible and was designed for many different possible symptoms and personality types.

The feedback is a vital part of this process and will help determine the accuracy of the results. The value of the assessment depends on a collaboration between us so you will be able to clarify and describe the way you see yourself. It would be ideal if together we could develop a picture of who you are.

A. Administration

- 1) give the booklet to the client and read the instructions to him/her
- 2) if the protocol is to be computer scored, be sure the client completely fills in the dots
 - a. not so much of a consideration if you are hand-scoring (which we are because we are not rich enough to computer score the protocols)
- 3) client doesn't have to complete the MMPI in 1 setting; they can take their time to complete it
- 4) it can be given in a group or individual format
- 5) items can be read or delivered via tape recorder
- 6) if the client cannot decide whether an item is true or false, tell him/her to choose what it is MOST OF THE TIME
 - a. if they persist, I usually tell them to decide what it is 51% of the time

B. Scoring

- 1) make sure the client has answered all the questions
 - a. when you get the protocol back, just scan it to make sure nothing was omitted. If you find some, have them re-do the questions
- 2) then, put the scoring templates over the answer protocol and count the dots that appear in the windows
 - a. be sure to double check your counting
 - b. also double check the placement of the scoring template to be sure that it is in the correct position

IV. Interpretation of the MMPI-2

A. Scales give results in T-Scores

M of 50; *SD* of 10

B. Check the validity of the test administration

Automated Scoring Program

Use Archive.org “Wayback Machine” for test items and automated computer scoring --- I have personally tested and verified its accuracy.

<http://geisel.narod.ru/mmpi2.htm>

Alternatively, the Scoring program has been embedded in this document – an offline version is available here:



MMPI-2 Scoring.html

Validity Scales

? Cannot Say

- a. items left unanswered or double answered
- b. 1-2 are normal
- c. Interpret with caution any protocol with 10 or more Cannot Say items
- d. Do not interpret any protocols with more than 30 Cannot Say items
 - 1. you can go back and encourage your client to complete the items
- e. Hypotheses for elevated scores
 - 1. Defensiveness
 - 2. Indecisiveness
 - 3. Fatigue, low mood
 - 4. Carelessness

5. Low reading skill

6. Perceived irrelevance of items

f. If the Cannot Say items fall primarily after item 370, you can interpret the Validity and Basic Scales, but not the Supplementary and Harris-Lingoes

L – Lying

Descriptors

Complaints

Feeling judged, unfairly criticized, or accused

Thoughts

Conventional, judgmental, moralistic, lacking in insight, inflexible, psychologically naïve

Emotions

self-controlled, denying, constricted emotionally

Traits and Behaviors

self-righteous, defensive, conscientious, rigid, naïve, perfectionistic, psychologically unsophisticated

Strengths

self-controlled, conscientious, conforming, high standards, independent, self-reliant

Therapist Notes

Characteristics associated with elevations on the L scale include not only defensiveness but also rigidity and a need to “put up a good front” (Butcher & Perry, 2008, p. 31). The original Minnesota normals had on average between eight and 10 years of formal education (Dahlstrom, Welsh, & Dahlstrom, 1972). A large portion, about 80%, of the 1989 restandardization sample normals had a college education, so they tended to obtain low L scale scores because they were sophisticated enough to see through the questions. Consequently, non-college educated individuals now score higher on the MMPI-2 L scale than they would have on the original MMPI when they were compared to other high school graduates. Elevations on the L scale can occur for a number of reasons. People who feel unfairly accused or judged can exhibit an understandable defensive response and attempt to present themselves as virtuous and above moral reproach.

Studies show that it is not uncommon, for example, for the L scores among individuals involved in child custody evaluations to be 1½ to 2½ raw scores higher than for the general normal

population (Bagby, Nicholson, Buis, Radovanovic, & Fidler, 1999; Posthuma & Harper, 1998). On the other hand, individuals who are psychologically naïve, black-and-white thinkers or who are rigid in their belief systems can also obtain high scores on the L scale. In this latter case, the L scale elevation reflects a rigid and judgmental personality style with values that don't allow for shades of gray. In other cases, the L scale may be elevated as a result of psychological constriction due to a psychotic disorder with prominent paranoid features (Coyle & Heap, 1965; Fjordbak, 1985). The L scale may also be elevated with individuals who have not carefully considered the items but are attempting to "pass" the test, answering the questions with a view to looking their best. It is important for the clinician to use the feedback statements with clients to explore and determine the source of L scale elevation variance. In cases where the high L scale elevation is the result of emotional constriction, denial, lack of insight, and a judgmental, critical personality structure, look for childhood histories of disapproving, fault-finding parents who imparted inflexible values. If the therapist determines that the L scale elevation is due to defensiveness, then the clinician needs to explore whether this reflects a repressing and conscious form of positive impression management or, less commonly, an unconscious defensiveness. Generally, the higher the elevation on the L scale, the lower the elevations to be on the clinical scales. In some cases, however (e.g., workers' compensation cases), it would not be unusual for the L scale to be elevated with clinical scale elevations revealing a repressed, inhibited, somatizing depression. In such instances, the L elevation could reflect conscious positive impression management as well as a rigid, naïve personality organization congruent with the elevations on Scales 1, 2, and 3. Exploration of clients' childhood experiences around value indoctrination, their level of psychological sophistication, and their motivation to appear unusually virtuous can help determine whether the L scale elevation reflects unconscious psychological rigidity, conscious distortion, or some combination of the two.

Lifestyle and Family Background

It is hard to know without an interview if the high L score is due to conscious defensiveness or unconscious rigidity of values and a lack of psychological sophistication. High L scores can be obtained from bright and educated people who nevertheless have very rigid values. In the presence of a lifestyle of rigid and judgmental attitudes, look for a history of strict and uncompromising parental values. If the high L is due to fears of being judged and reflects a conscious attempt to "pass" the test, explore the clients' fears about how the results of the test may be used as well as the possibility of a future retest.

Modifying Scales

- When the Correction (K), Positive Malinger (Mp), or Social Desirability (Sd) scales are also elevated, the high L is likely due to conscious positive impression management. If these other scales are within normal limits, the L elevation may be reflecting a rigid black-and-white personality style.

- When Scale 6 is elevated, the L score may indicate fears of being judged and criticized as in a criminal defense case or a paranoid disorder.

Therapy and Therapeutic Pitfalls

Validating the clients' desire to be above moral reproach would be an important initial alliance-building strategy. Beware of clients feeling judged by the therapist and eliciting countertransference because of their defensiveness and judgmental attitude. Educating clients about how people have different values and how the rigidity of their own may make others defensive around them could help them to become more flexible. Also explore early parental demands for strict "goodness" and the pressure to perform and be pleasing to avoid criticism.

Feedback Statements – Elevated Profiles (T-Score > 65)

Feeling Judged or unfairly Accused

Your profile suggests that you may be feeling vulnerable to being judged. Perhaps you took the test against your will, or you may think the results are going to be used against you. You answered a number of questions that indicate you want the psychologist to know that you are a person who is above criticism and has high moral standards.

Conventional

People with your profile tend to have conventional values and a strong belief about the right and wrong way of doing things. People may see you as straightlaced and uncomfortable with people who don't share your values.

Judgmental or Moralistic

Because you have high personal standards and such a strong sense of the right and wrong way to behave, others may see you as somewhat judgmental or critical of them. People with your profile can be seen by others as having a tendency to scrutinize others' moral behavior.

Conscientious or self-Controlled

You work hard to follow the rules and do the right thing. You answered the test in a manner that suggests that you control your emotions to make sure your feelings and behaviors are above moral reproach.

Lacking Insight

The way you answered the test items suggests that you tend to see the world in somewhat black-and-white terms. Because of this, people may see you as lacking insight into normal human frailties. Because of your strong sense of values and morals, you may come across as unaware of the shades of gray that typify most people's moral judgment.

Defensive

It's possible that you answered the test cautiously, putting your best foot forward and wanting to minimize the possibility of others judging or criticizing you. It may be that you are the kind of person who goes through life guarded about doing anything that could lead others to find fault with you.

Rigid or Perfectionist

People may see the fact that you are so cautious about doing the right thing as somewhat rigid and inflexible. Your high standards may lead others to see you as demanding perfection and as being unreasonably critical of others. People may find it hard to live up to your high standards and may want to argue with you or resist your values. **LIFeStyle And bACkground FEEdbACk** You may have grown up in an environment where parental figures were critical and judgmental and moral standards were hard to live up to. Perhaps you follow a strict religious code of conduct that does not allow for moral shades of gray. It's also possible you are wary of how the test results could be used against you, so you were careful to reveal your "best side."

Treatment and Self-Help Suggestions

1. Talk to your therapist about using cognitive-behavioral tools to help modify your "black-and-white" and "all-or-nothing" thinking.
2. Work with your therapist to explore any early experiences where you felt you had to be above criticism. Once you have identified those experiences, you and your therapist can use cognitive-behavioral techniques to challenge and modify those early childhood assumptions.
3. Because you tend to be a perfectionist, "thought-stopping" techniques can help you manage the negative thoughts that you are not doing things "well enough." Whenever you become aware of critical thoughts about others, forcefully say to yourself, "Stop." Some people find it helpful to picture a large red stop sign at the same time. Some critical and negative thoughts tend to repeat themselves, so this is a way to recognize and disrupt unhealthy thought patterns. Repeat the technique until the thought is out of your mind. You can then replace it with a more positive and constructive thought (e.g., "I have felt this way before, and I know I can handle this").

Normal Range Feedback (T-Score 50 to 65)

Your score on this scale is in the normal range. You were able to achieve an appropriate balance between being honest and the temptation to create an overly favorable impression of yourself. You admitted to normal human failings, showing you have good self-awareness and the confidence to be yourself. You were honest about your strengths and vulnerabilities.

This scale is usually measuring the degree to which a person is trying to look good in an obvious way. The higher the scale, the more the individual is claiming socially correct behavior. The lower the scale, the more the person is willing to own up to general human weaknesses.

Our experience indicates that the L scale is nearly always below a T of 50 and is rarely above a T of 60. People scoring at a T of 55 or above on this scale may be presenting themselves as morally righteous, although this in fact may not be true. Job applicants, for example, tend to have an elevated L because they wish to impress the person doing the hiring.

In mental health centers, an elevation on this scale frequently indicates a rather naive person who has not thought deeply about human behavior, particularly his/her own. In a college setting, an elevated L, particularly with a slightly elevated 3 scale, frequently indicates people who like to look on the bright side of life and do not like to think bad thoughts about themselves or others. Thus, the exact inference to be construed from an elevated L depends upon the person's background, setting, and purpose for taking the inventory.

Scores at the low end of this scale indicate a person who is not socially naive, at least to the extent of claiming social virtues he/she does not have.

This 15-item scale measures naive defensiveness and an attempt to appear extremely virtuous, well-controlled, and free from commonplace human frailties. The impact of naive defensiveness (T greater than 60) is usually to lower scores on some of the clinical scales. However, high scores on clinical scales sometimes occur even in defensive protocols, and these scores indicate problem areas that should be addressed. Scores above 60T on L suggest a rigid and ineffective style of coping with problems, denial, limited self-awareness, and limited insight into the manner in which one's behavior affects others. In brain-damaged samples, scores on L have been linked with the extent of cognitive impairment (Dikmen & Reitan, 1974, 1977; Gass & Ansley, 1994). In a mixed neurological sample, scores on the L scale were mildly predictive of the degree of neuropsychological impairment on the Average Impairment Rating scale, $r(144) = -.27, p < .005$ (Gass, 1997). Individuals who have brain damage and score high on the L scale underestimate their acquired cognitive deficits, make poor decisions, and take on tasks that are beyond their capability.

- a. this scale attempts to detect a deliberate and unsophisticated attempt of the client to present himself/herself in a favorable light
- b. 15 rationally-derived items deal with minor flaws and weaknesses most people are willing to admit

1. *Examples: 29. At times I feel like swearing. (F)*

51. *I do not read every editorial in the newspaper every day. (F)*

c. scores are negatively related to educational level, socioeconomic level, and psychological sophistication

T-Score > 65 = an overly virtuous presentation

T-Score 60-64 = an attempt to impress

d. T-Scores < 65 are indicative of individuals who:

1. trying to create favorable impression of themselves by not being totally honest
2. may be defensive, denying, and repressing
3. may be confused
4. may be self-controlled and manifests little or no insight into their motivations
5. show little awareness of consequences to other people resulting from their behavior
6. tend to overvalue their own worth
7. tend to be conventional and socially conforming
8. are unoriginal in thinking and inflexible in problem solving
9. are rigid and moralistic
10. have poor tolerance for stress and pressure
11. may be unsophisticated and are trying to make a favorable impression

12. profiles with T-Scores > 65 should not be interpreted as they are invalid

e. T-Scores between 56-64 are indicative of individuals who:

1. are more conforming than usual
2. have a tendency to resort to denial mechanisms

f. Normal Range: T45-55

g. T-Scores < 45 are indicative of individuals who:

1. probably responded frankly to the items
 2. are confident enough about themselves to be able to admit minor faults
 3. in some cases, may be exaggerating negative characteristics
 4. are perceptive and socially reliant
 5. are seen as strong and relaxed
 6. are self-reliant and independent
 7. can function effectively in leadership roles
 8. communicate ideas effectively
 9. may be described by others as cynical and sarcastic
- h. caveat: ministers sometimes will have elevated L Scales because they truly do not do

the behaviors

F – Infrequency

Descriptors

Complaints

stressed, unsatisfied, panicked, pleading for help, confused, possible reality distortions, alienated

Thoughts

low self-esteem, self-deprecating, identity confusion, disorganized

Emotions

moody, unstable, mixed, angry, fearful

Traits and Behaviors

traits and behaviors dependent on the clinical scale elevations

Strengths

unconventional, challenges the status quo

Therapist's Notes

Normal-range scores indicate a willingness to be open and honest about any unusual experiences and freedom from major psychopathology. F scale elevations are one of the best predictors of validity (Berry, Baer, & Harris, 1991). The F scale elevations also reflect clients' current levels of pain, fear, and their general level of psychological organization and stability. The scale consists of unambiguous content areas of physical symptoms, paranoid ideation, psychotic traits, family enmity, schizoid underinvolvement, psychotic processes, and a compulsion to pathological activity. F scale scores above a T-score of 85 are not always invalid. Although they may indicate overreported psychopathology, they may also reflect severe distress, disorganized, possibly psychotic thinking, or behavior disorders. In some psychiatric settings where clients are extremely disturbed or in cases where young adults have experienced a panic disorder following bad drug reactions, highly elevated, but valid, F scores are not uncommon. However, with F above a T-score of 85, the clinical scale elevations are less likely to be stable on retest. F scores between a T-score of 55 and 65 reflect the endorsement of some unusual items and, therefore, a certain level of psychological pain and distress. However, elevations of F in this normal range could also reflect eccentricity, nonconformity, or a situational adjustment reaction. The higher the F scale score, the more likely the clients are experiencing disruptions in

cognitive and behavioral efficiency and emotional stability. In the presence of elevated clinical scales, T-scores between 55 and 65 suggest a stable, perhaps ego syntonic disturbance.

F elevations between 55 and 65 in the presence of a low clinical profile would predict unconventional, although not necessarily disturbed, individuals. F scores below a T-score of 50 could reflect someone who is denying and defensive, especially if the K and L scales are elevated. A low F score may also reflect conventional but stable, psychologically well-balanced individuals who have few complaints and no psychological impairment. Determining validity is a multivariate process. It involves examining all of the validity scales, taking into consideration the setting and the clients' motivation to employ positive or negative impression management. When giving feedback, discuss high F elevations as reflecting clients' levels of pain and concern about their psychological state. Even when profiles are exaggerated, it may be useful to tell clients that the F scale reflects that they may be panicked and pleading for help from the therapist. In cases where malingering is suspected, discuss that they may have taken the test wanting to make sure that the therapist knew they were experiencing mental problems and, in the process, exaggerated some of their symptoms and disturbed behaviors.

LIFeStyle And FAMIlly bACkground

When the F scale elevation reflects overendorsement due to panic or a need to appear disturbed, there is no consistent lifestyle and family background. In some cases, however, high elevations on the F scale reflect a stable, although disturbed, personality organization. These elevations are associated with a chaotic, emotionally unstable lifestyle and backgrounds of neglect, abuse, or psychological trauma. In situations where the F scale reflects a recent crisis or trauma and subsequent psychological collapse, the lifestyle of these individuals tends to be chaotic, with unstable relationships and general inefficiency and disorganization.

Modifying Scales

- When Dissimulation (Ds), Infrequency Psychopathology (Fp), and Back Infrequency (Fb) are elevated above a T-score of 85, consider exaggeration or malingering. If Fp is below a T-score of 80, high F scores may be reflecting a severe mental disturbance.

Therapy and Therapeutic Pitfalls

As the F scale goes up above a T-score of 65, the goal of therapy is stabilization. Supportive, practical treatment strategies as well as medication referrals are often appropriate for these individuals. When the high F score reflects a panic or plea for help, therapy should include risk assessment, possible hospitalization, and ongoing monitoring of their condition. Avoid insight-oriented therapies that could overload individuals who may already be emotionally and cognitively disorganized. Moderate scale elevations between a T-score of 55 and 65 suggest a more stable disorder; the code type will indicate treatment strategies.

Normal Range Feedback (t-sCorE 45 to 55)

The score on this scale is in the normal range. This is where we expect your score to fall when you feel free of psychological distress or have done a good job of minimizing its impact on you. Your profile suggests moderate distress and discomfort. You have somehow learned to manage its effect.

Feedback Statements—Elevated Profiles (T-Score > 65)

Stress, Panic, or Feeling Alienated

Your profile suggests that currently you are feeling a great deal of stress and emotional turmoil. You may be panicked by how you are feeling, and you may be overwhelmed by unpleasant feelings and thoughts. Sometimes when you feel worse, you may be extremely fearful that your life is out of control. Because you often feel confused and tense, it is hard for you to connect with other people. You may feel others don't understand the distress you feel, so it leaves you feeling isolated and alone.

Pleading for help

Sometimes when people feel panicked and out of control, they feel a sense of desperation and want somebody to help them. Your profile suggests that you are asking for psychological help and want your therapist to know that you feel distressed and, at times, desperate.

Confused or disorganized

Your profile suggests that you may be experiencing a lot of confusion with many competing thoughts and emotions. It may be hard for you to think clearly and to organize your thoughts and label your emotions. This confusion may make you less efficient and may frighten you.

Unconventional

People with your profile generally think differently than others. It may be due to some recent stress or trauma, or it may be that you've always looked at things somewhat differently than others.

Moody or unstable

Your feelings may sweep over you so that you're caught off guard, and you may experience sudden shifts in your mood. One moment you may find yourself happy and upbeat, perhaps without knowing why, and then you can feel down and unhappy for no apparent cause.

Lifestyle and Family Background Feedback

Your profile suggests you may have experienced some recent trauma or setbacks that are causing you fear, anxiety, and unhappiness. Perhaps growing up you experienced painful losses, unsupportive adults, or even some kind of neglect and abuse. Recent events may have restimulated old psychological scar tissue, making current painful events even more difficult.

Treatment and Self-Help Suggestions

1. Discuss with your doctor whether medications might help you feel better and more in control. Avoid alcohol or illegal chemical agents as a way of feeling better, as this can actually make you feel worse. 2. People with your profile feel better in structured, safe environments. Until you feel better, avoid stressful situations, and try to take good care of yourself by being with people around whom you feel safe. 3. If you do feel panic, there are things you can do to minimize the likelihood that you will experience a panic attack. Start by decreasing or eliminating caffeine, as some people are sensitive to its effects. Your therapist can also help you with deep breathing and relaxation exercises.

Experience with mental health clinic and college counseling populations suggests that the F scale is nearly always measuring the degree to which a person's thoughts are different from those of the general population. Only rarely is an elevated F indicative of purposeful faking-bad in these populations. As the elevation increases, subjects seem to be reporting an increasing number of unusual thoughts and experiences. With a college population or with creative people, different thoughts, to a mild degree, are not uncommon, and an F of 65 may be quite typical. When people become involved intensely in unusual religious, political, or social groups, they frequently have elevations on the scale as high as 75. However, when elevations go beyond 75, usually the person is using the F scale to request help by reporting many unusual thoughts and happenings.

In a mental health setting, the elevations do not have to be as high as 75 for the request-for-help interpretation to be made. For example, a T of 65 in this population may indicate that the person is having difficulty in some one area of

life. As the elevation increases, the person tends to report an increasing number of problem areas and a greater degree of severity of the problems.

Elevations above 100 in either population limit the profile as an instrument for diagnosis. With an elevation above 100 on F, usually an elevation occurs on all of the Clinical scales. Such a profile generally indicates that the person is unable to pinpoint any one area of concern and is reacting to everything.

Low F scores usually indicate a person who feels he/she is relatively free from stresses and problems.

This scale was designed to detect deviant ways of responding, but it is best recognized for measuring degree of openness in reporting problems. These problems may be real, embellished, or completely faked. Scores on Scale F are sensitive to a variety of situations, including severe psychopathology, symptom feigning or exaggeration, random responding, and atypical item interpretation (Arbisi & Ben-Porath, 1995). Many clinicians erroneously discard protocols that have high F or F(B) scale scores (T greater than 80) on the grounds of suspected faking-bad. In many clinical settings, such scores commonly reflect severe psychopathology, and the protocols are quite valid. Of course, other reasons such as exaggeration, malingering, and content-independent responding should be ruled out. A high F or F(B) score does not, in itself, invalidate a protocol, since extreme scores occur in the presence of severe psychopathology (Graham, Watts, & Timbrook, 1991). Indiscriminate responding must be ruled out (VRIN and TRIN must both be less than SOT). Severe psychopathology is more likely if a high score on F is accompanied by a low Fp (T less than 80). In the presence of a high score on F (T greater than 80), a high Fp score suggests possible symptom exaggeration or faking. In the absence of a high F scale score, a high Fp score may be a less reliable indicator of symptom fabrication (Gass & Luis, 2001a). In personal injury settings involving claims of brain injury, some individuals feign emotional pathology resulting in very high F-scale scores (Berry, Wetter, Baer, Youngjohn, et al., 1995), whereas others restrict their faking to cognitive and somatic symptoms of brain damage (Greiffenstein, Gola, & Baker, 1995; Larrabee, 1998). Although the latter obtain higher scores on scales 1 and 3, they do not typically produce high scores on the F, F(B), or Fp scales.

a. 60 items reflecting infrequently endorsed items

1. *Examples: 36. I have a cough most of the time. (T)*

78. *I am liked by most people who know me. (F)*

b. a measure of symptom exaggeration

1. faking bad

c. **T-Scores > 100 are indicative of individuals who:**

1. may have responded randomly to MMPI-2 items

2. may have responded either all True or all False

3. may have been faking bad responses
4. if hospitalized psychiatric patients, may manifest:
 - a) delusions
 - b) visual and/or auditory hallucinations
 - c) reduced speech
 - d) withdrawal
 - e) poor judgment
 - f) short attention span
 - g) lack of knowledge of reasons for hospitalization
 - h) psychotic diagnosis
 - i) some other signs of organicity

d. T-Scores 80-99 are indicative of individuals who:

1. may be malingering
2. may be exaggerating symptoms and problems as a plea for help
3. may be quite resistant to the testing procedure
4. may be clearly psychotic by the usual criteria

e. T-Scores 65-79 are indicative of individuals who:

1. may have very deviant social, political, or religious convictions
2. may manifest clinically severe neurotic or psychotic disorders
3. if relatively free of psychopathology, are usually described as:
 - a) moody
 - b) restless
 - c) dissatisfied
 - d) changeable, unstable
 - e) curious, complex
 - f) opinionated
 - g) opportunistic
4. have endorsed items relevant to some particular problem area
5. typically function adequately in most aspects of their life situations

f. Low scores on the F Scale ($T < 50$) are indicative of individuals who:

1. answered items as most normal people do
2. are likely to be free of disabling psychopathology

- 3. are socially conforming
- 4. may have faked good
- g. T-Scores > 100 are generally invalid, but some profiles of psychiatric patients and recently admitted felons can be interpreted if VRIN is in the valid range

Infrequency Back (Fb)

- a. assesses the endorsement of low frequency items on the latter part of the MMPI-2
- b. measures the same constructs as the F Scale
- c. **T-Scores > 110**
 - 1. indicate an invalid protocol, especially if F Scale is > 110
- d. **T-Scores < 89**
 - 1. if F Scale T-Score is < 89, indicate a valid approach to the test
 - 2. if F Scale T-Score is > 89, do not interpret Content or Harris-Lingoes Scales
- e. Use the hypotheses for the F Scale when considering reasons for elevated scores, but also consider:
 - 1. a recording error
 - 2. client is responding randomly to items
 - 3. client is exaggerating existing symptoms
 - 4. client is faking a psychological problem
 - 5. client is malingering
 - 6. client has severe psychopathology
 - 7. client was tired of the test

BACK infrequenCy SCaLe (fB)

Descriptors

Complaints Concentration difficulties, fatigue, depression, low self-esteem, suicidal thoughts, fearfulness, panic attacks, disturbed or estranged family relationships, substance abuse

Thoughts hopeless, fearful, confused

Emotions distressed, depressed, hopeless, apprehensive, panicked

Traits and Behaviors overreporting of symptoms, perhaps exaggerating, anxious or fearful, prone to substance abuse

Strengths this scale measures distress and psychological disorganization, so strengths are not associated with this scale's elevation

Therapist Notes

The Fb scale was developed in the same manner as the F scale; any item on the second half of the test that was marked by fewer than 15% of the new restandardization sample became an Fb item. Individuals scoring high on Fb are reporting unusual symptoms such as feeling disturbed, knocked off balance, unhappy, panicked, and unable to concentrate and operate efficiently. Fb elevations above a T-score of 85 suggest a possible exaggeration and malingering, perhaps as a plea for help or as an attempt at manipulation. Nichols (2011), in examining the content of the F and Fb scales, noted that the F scale contains many psychotic items so that when the F scale is elevated the disturbance could be reflecting a psychotic thought process. However, the Fb scale has few psychotic items and contains many items associated with the collapse of an individual's lifestyle and associated fearfulness, dysphoria, and drug or alcohol abuse. Fb may be more elevated than the F scale without necessarily suggesting invalidity. In the presence of a history of turmoil associated with drug and alcohol abuse or suicide attempts, the Fb scale may be significantly more elevated than the F scale. As stated previously, validity is a multivariate process, and no one scale elevation should rule out validity. However, as the Fb approaches 90 and above, invalidity of the content and supplementary scales should be suspected, either due to panic, plea for help, or conscious malingering.

Lifestyle and Family Background

Typically, the Fb scale is associated with mental disturbance, drug or alcohol abuse, depression, anxiety, and general inefficiency. A comprehensive history can determine whether it is the result of an acute disorder due to recent trauma or a lifestyle of marginal adjustment.

Modifying Scales

- When Fb, Infrequency Psychopathology (Fp), Infrequency (F), and the supplementary scale Dissimulation (Ds) are all above a T-score of 85, then the profile may be exaggerated. If all of these validity scales are above a T-score of 90, the profile is probably exaggerated and invalid. However, if Fb is at a T-score of 90 or even 95, the F scale T-score is 85 or below, and the Fp is below a T-score of 85, the profile may be valid but reflecting a recent collapse of ego strength and lifestyle due to a serious disturbance.

Therapy and Therapeutic Pitfalls

As with the other validity indicators of acute distress, stabilizing these clients is the immediate concern. Assessing for self-harm and drug use would be the immediate focus of intervention. Long-term therapy would involve a medication evaluation, behavior modification, or cognitive-behavioral therapy (CBT) to address panic and fear and basic self-care skills and to help these individuals manage impulsive behavior, such as substance abuse. Learning self-efficacy is usually more relevant than dynamically oriented insight therapy.

Feedback Statements

There are no feedback statements for this validity scale.

Treatment and Self-Help Suggestions

1. Work with your therapist to switch off panic and negative thoughts by examining any automatic self-negating and catastrophizing thoughts that are contributing to your anxiety. 2. Work on relaxation techniques, meditation, and yoga as a way of relieving stress. These techniques are tools that, when practiced regularly, have been shown to reduce heart rate, muscle tension, and blood pressure and also to increase well-being.¹ Your therapist can help you choose the method that will be best for you. 3. You and your therapist may decide you could benefit from medication so you can give your nervous system a temporary rest. Sleeping and eating well and avoiding chemical agents would also be important to help you feel more in control. 4. You may have moments when you feel so overwhelmed you may want to act impulsively and do something that could be self-destructive. Try to stand back as if you are watching yourself from above; take a deep breath, seeing the bigger picture of your life and knowing the stress will pass.

¹ Relaxation techniques have been used for many years to combat the effects of stress, anxiety, and depression. These techniques can be easily incorporated into everyday routines, can be quickly taught, and can give fast relief.

Meditation is a promising intervention for anxiety and depression (Hoffman, Sawyer, Wit, & Oh, 2010).

Infrequency Psychopathology Scale (Fp)

Descriptors Complaints disturbed thinking, alienated distress, possible chemical abuse/addiction, inefficiency, family problems

Thoughts Confused, self-depreciating, ambivalent, indecisive

Emotions emotional turmoil, depression, anxiety, conflicted

Traits and Behaviors possible exaggeration and overreporting of symptoms, ineffective, disorganized, self-defeating, possibly suicidal

Strengths this scale measures distress and disturbance. possible strengths can be determined through the clinical scale elevations.

therapist's notes

Elevations on the Fp scale suggest someone who has answered the test in a highly unusual fashion. In some cases of extreme disturbance, an Fp score with a T-score of 90 can still be valid, especially if elevated due to four items overlapping L (items 51F, 77F, 93F, and 102F) or the four items related to family enmity and discord (90F, 192F, 276F, and 478T). However, if the F, Fb, and other measures of exaggeration are severely elevated, then an Fp score above a T-score of 90 suggests invalidity. In some rare cases, the Fp scale can be elevated in the absence of severe psychopathology, reflecting unconventional, unusual individuals with eccentricities and amoral attitudes but not mental disorder. When Fp is below a T-score of 65 and other measures of validity suggest a severe disturbance, the Fp score would imply that the profile reflects real pathology rather than exaggeration. Fp T-scores in excess of 100, together with Variable Response Inconsistency (VRIN) T-scores above 80, may be indicative of random responding to the test questions.

Lifestyle and Family Background

This is not applicable.

Modifying scales

- When the traditional validity scales Infrequency (F), Back Infrequency (Fb), and Dissimulation (Ds) are in valid range, elevations on Fp should not invalidate the profile. However, the source of the elevation on Fp should be explored.

therapy And therapeutic Pitfalls

This is not applicable.

Feedback statements

There are no feedback statements for this validity scale.

trEAtMEnt And sElF-hElP suggEstIons

This is not applicable.

K – Defensiveness

This scale measures defensiveness and guardedness. Therefore, it evaluates some of the same behavior as the L scale but much more subtly.

In order to evaluate the K scale properly, the specific population, college or mental health center, must be noted. In addition, the K scale interpretation must be modified for special groups of people within the population. In this introduction are discussed the usual interpretations for the two major populations with whom this book is concerned and, when appropriate, modifications are noted.

In a college population, a T-score on this scale between 55 and 70 is typical. People scoring in this range are indicating that their lives are satisfactory, that they are basically competent, and that they can manage their lives. Such scores are usual for people coming for counseling about an academic major or for students taking the MMPI as part of some experiment. When $T = 70$ or above for the K scale, these people are indicating not only that they are competent people and can manage their own lives, but also that they are being a bit cautious about revealing themselves. Such scores are usually attained when a person is defensive, and/or when the test administrator does not fully explain the reason for the test, the use to which it will be put, or the confidentiality of the results.

When K is below 45 and the F scale is elevated above 60 T-score points, the college student may be experiencing some stress. The K scale score usually elevates to the 55 through 65 range when the stress is alleviated.

When K is below 45 and the F scale is below 60 score points, the college student may be feeling that life has been rough, that he/she has had fewer advantages than most people.

In a mental health setting, if the client is having difficulties, he/she usually scores below 45 on the K scale. The severity of the problem is usually indicated by how low the K score is (the lower the score, the more severe the problem). Below a T-score of 35, the prognosis for successful therapy is poor. A score in this range does not indicate that the person will or should be hospitalized for his/her problem, but more that the person is unable to improve at this time. Scores between 35 and 45 typically reflect situational difficulties, such as marriage, family, or job problems. Elevations over 55 are unusual in the mental health population and for people who do not have some college education and/or are unsuccessful in business. Typically such scores are attained by persons who blame others for

their situation, e.g., the other mate in marriage counseling. A person in this range also may be bringing someone else in to be counseled, such as a parent who brings a child in with school difficulties. As the K goes above 60, defensiveness is usually present. When the person has a T score over 70, the prognosis for the person recognizing problems he/she may have is poor. Marks, Seeman, and Haller's(1974)"K + " profile should be studied for further information concerning this pattern. See point 7 under the marked elevations.

College counseling and mental health centers personnel frequently evaluate persons for other agencies. In these instances, the above rules for interpretation of the K scale do not always hold since the person may have an ulterior motive for taking the test, rather than just taking it to tell how he/she is at the moment. Persons applying for jobs and students being screened for specific programs (doctoral admissions, for example) may have a T-score of approximately 70. Conversely persons applying for such thing as disability pensions (where the person wishes to look bad) tend to }we unusually low K scores and elevated F scores.

Persons under scrutiny by the courts may have either high or low K scores, depending upon their situations. If the person is seeking parole or wishes to win custody of his/her child, a high K score may be obtained. If the person is seeking to avoid a sentence by appearing to be mentally ill, a low K score may result. Therefore, in these special instances the examiner must know the purpose of the examination and what the person expects to gain from it.

When the L scale (T = 60 or above), the 3 scale (T= 70 or above),and/or the R scale (T = 60 or above) are elevated with the K scale (T =65 or above), the diagnosis of defensiveness is reinforced. The person not only does not want to look bad to others (L and K elevations), he/she does not want to think badly of others (3 scale elevation), and he/she also does not want to look or talk about certain areas of life (R scale elevation).

This scale measures sophisticated defensiveness and a desire to portray oneself as psychologically well-adjusted and emotionally healthy. Contrary to the interpretive practice of many clinicians, scores on K (and other scales) are largely independent of the examinee's educational background. Data from the MMPI-2 normative study demonstrate that level of education has virtually no influence on MMPI-2 scores. High scores on K (T greater than 60) are associated with a denial of behavioral and emotional problems and lower scores across the clinical profile. Physical problems, however, may be reported, yielding higher, scores on 1 and 3. The high K scorer denies a need for psychological intervention and is reluctant to discuss feelings. Protocols with elevated K-scale scores are sometimes deemed invalid and subsequently ignored, even when high scores exist on one or more of the clinical scales. In these cases, the elevated scores on the clinical scales suggest problem areas that should not be overlooked. For example, the 13 and 49 code types are sometimes found in defensive protocols, and the associated behavioral correlates of these code types are typically applicable in these cases. The presence of the high K score does not invariably mean that the entire clinical profile should be ignored. It does indicate, however, that other psychological problems may

exist that were unreported and that low or normal-range scores across the clinical scales cannot be accepted as valid indicators of psychological status.

a. measures of **test defensiveness**

b. assesses the willingness of the client to disclose personal information and to discuss his/her problems

1. *Examples: 83. I have very few quarrels with members of my family. (T)*

110. *Most people will use somewhat unfair means to gain profit or an advantage rather than to lose it. (F)*

c. K score is used to adjust Hs, Pd, Pt, Sc, and Ma Scales

d. **T-Scores > 65 are indicative of individuals who:**

1. may have responded false to most of the items
2. may have tried to fake good
3. may be trying to give an appearance of adequacy, control, and effectiveness
4. are shy and inhibited
5. are hesitant about becoming emotionally involved with people
6. are intolerant and unaccepting of unconventional attitudes and beliefs in others
7. lack insight and self-understanding
8. are not likely to display overt delinquent behavior
9. if clinical scales are also elevated, may be seriously disturbed psychologically but have no awareness of it
10. if not seriously disturbed psychologically, may have above-average ego strength and other positive characteristics

e. **T-Scores 56-64 are indicative of individuals who:**

1. are being defensive and unwilling to acknowledge psychological distress
2. may exhibit denial and hysteroid defenses (especially in lower SES)

f. **T-Scores 41-55 are indicative of individuals who:**

1. maintain a healthy balance between positive self-evaluation and self-criticism
2. are psychologically well-adjusted
3. show few overt signs of emotional disturbance
4. are independent and self-reliant
5. are capable of dealing with problems in day-to-day life
6. exhibit wide interests

7. are ingenious, enterprising, versatile, and resourceful
8. are clear thinking and approach problems in reasonable and systematic ways
9. are good mixers socially
10. are enthusiastic and verbally fluent
11. take ascendant roles in relationships

g. T-Scores 35-40 are indicative of individuals who:

1. are experiencing severe distress that is being openly acknowledged
2. have poor self-concepts and are strongly self-dissatisfied, but lack either interpersonal skills or techniques necessary to alter the situation
3. may tend to be excessively open and revealing
4. in lower SES, may indicate a moderate disturbance
5. in higher SES, indicates more serious distress

f. T-Scores < 35 are indicative of persons who:

1. may have responded true to most of the items
2. may have faked bad
3. may be exaggerating problems as a cry for help
4. may exhibit acute psychotic or organic confusion
5. are critical of self and others and are dissatisfied with the self
6. are ineffective in dealing with problems of daily life
7. show little insight into their own motives and behaviors
8. are socially conforming
9. are overly compliant with authority
10. have a slow personal tempo
11. are inhibited, retiring, and shallow
12. are socially awkward
13. are blunt and harsh in social situations
14. are cynical, skeptical, caustic, and disbelieving
15. are suspicious about the motivations of others

High K (T-score > 65)

Descriptors

Complaints Few or no complaints

Thoughts denying, conventional, rational, logical

Emotions defensive, emotionally constricted, underreporting of feelings, guarded, controlled, “stiff upper lip”

Traits and Behaviors Controlling, uncomfortable with emotionality, conventional, conforming, socially appropriate, lacking self-awareness

Strengths socially appropriate, self-reliant, positive self-concept, resilient, strong capacity to manage emotional stress

Therapist's Notes

High K scores are associated with defensiveness, emotional constriction, and conventionality. As a result, the therapist will have to multiply the intensity of what the clients are saying to gain a true sense of empathy for them (Caldwell, 2008). High K scores can occur for a number of reasons. Clients who are consciously defensive and are attempting to “pass” the test may obtain high K scores. However, in other cases, a high K score occurs as a reflection of these individuals' upper socioeconomic status. People from wealthier backgrounds tend to espouse a cultural value of control, constraint, and social appropriateness (Caldwell). In some cultures, for example, British culture, expressing emotions publicly is frowned upon and seen as inappropriate (Wagstaff & Rowledge, 1995). Approaching emotionally upsetting situations with a “stiff upper lip” and denying extreme emotions is seen as appropriate and desirable. In such individuals, high K scores reflect a cultural bias toward control and poise (Reynolds & Fletcher-Janzen, 2002). In some situations, high K scores may be better understood as reflecting personality variables rather than test-taking defensiveness. These individuals are likely to be poised, emotionally controlled, and able to manage stressful situations unusually well. It is important for the psychologist to determine the source of high K variance. Is the high K score due to conscious attempts to look good and “pass” the test, or is it an unconscious manifestation of socioeconomic and cultural influences? It would be misguided to rule a high K profile invalid if it, in fact, reflects an emotionally controlled, tightly wound, and constricted personality type.

Lifestyle and Family Background

Elevations on K, whether high or low, are probably not associated with any particular lifestyle or family background. In some cases, when high K elevations are associated with upper socioeconomic status, the lifestyle reflects upwardly mobile individuals, usually of above-average education, whose emotions are rarely out of control.

Modifying Scales

- When Positive Malinger (Mp) and Social Desirability (Sd) are not elevated above a T-score of 65, then the high K score may reflect a personality style of emotional poise and control rather than a conscious attempt to appear

emotionally stable. In other words, the K elevation is measuring a personality attribute rather than a pure validity construct. If Mp and Sd are above a T-score of 65, then the K elevation may be due to conscious attempts to pass the test by appearing emotionally stable and balanced.

Therapy and Therapeutic Pitfalls

Typically, individuals with high K elevations are not amenable to cathartic and insight-oriented therapies. This is partially because they are reporting emotional balance and control but also because they may be threatened by emotionality. Therapy with these individuals can start by being intellectual, fostering understanding about how others experience emotions. The therapist can help these clients understand how they have learned to modulate their emotion through cultural or learned inhibitions against emotional expressiveness. Once these clients are comfortable discussing emotions gestalt techniques or role-playing can help free up their emotion. Sometimes taking an improvisation class or acting lessons can help them become more emotionally expressive.

Feedback Statements—Elevated Profiles (T-score > 65)

Conventional, rational, logical

You are a person who could be described as conventional; doing things in a socially appropriate way is important to you. You tend to approach life in a rational or logical way—to analyze emotions and understand them so they don't knock you off balance.

Defensive

You approached the test putting your best foot forward and being cautious to not come across as socially inappropriate or emotionally unbalanced. People may see you as defensive because you dislike the expression of intense emotions. It is likely that you rarely feel out of control with your feelings.

Emotionally Constricted

You are careful not to wear your feelings “on your sleeve.” People may see you as a little emotionally constricted because you don't often express extremes of emotions. People will have to multiply the intensity of what you're saying to get a sense of empathy for you.

Lacking self-Awareness

People with your profile tend to not spend much time thinking and analyzing their own feelings. They tend to go through life working hard to avoid emotional upset. They may not always be aware of what they are feeling and how their emotions drive some of their behaviors.

Resilience

In a crisis, when others are becoming emotional, you are unlikely to lose your head. You will appear cool, calm, and collected so that others will have difficulty reading how you might be feeling. You appear to manage emotionally upsetting situations well, rarely feeling knocked off balance.

Treatment and Self-Help Suggestions

1. Start by learning to recognize your emotions. You and your therapist can work together to identify any feelings you may be experiencing during the therapy session. Think of a positive emotional experience, and take some time to identify where in your body you experience the feelings. Do the same for a negative experience. Observe to see if you inhibit emotions from becoming too intense.
2. Explore any childhood or later experiences where you felt the potential for losing emotional control. Revisit and allow yourself to feel those moments, so you can learn the full range of emotional expression.
3. Be mindful that when you express your emotions you may do it in a muted way so others don't have a full sense of empathy for you. Occasionally ask others how they perceive you are feeling so you don't lose emotional contact with them.
4. As you begin to feel more comfortable with the idea of expressing feelings, acting classes can help you become more spontaneous and perhaps even more creative.
5. Resilience building: Familiarize yourself with the benefits of "emotional intelligence," which is the ability to identify, assess, and manage your emotions in a healthy way. There are many good self-help books written about developing emotional intelligence to make improvements in both your personal life and in the workplace.¹

¹ Emotional intelligence has been demonstrated as an effective tool in building competency, fostering successful relationships, and creating enhanced performance in work settings (Boyatzis, Goleman, & Rhee, 2000).

Normal-Range Feedback

See normal-range feedback for low K.

Low K
(T-score < 45)

Descriptors

Complaints overwhelmed, insecure, sometimes confused, inefficient, vulnerable to stress, low self-esteem

Thoughts self-doubting, self-critical, inchoate, frightened, disorganized, jaded or cynical view of others

Emotions Fearful, ambivalent, overwhelmed, underregulated, alienated from others

Traits and Behaviors direct, nondefensive, easily overwhelmed, cynical, complaining, impulsive, demanding

Strengths open, honest, candid, spontaneous, emotionally authentic

Therapist's Notes

Low scores on Scale K suggest directness, nondefensiveness, vulnerability, and emotional undercontrol. When the clinical scales are elevated in the presence of low K, this suggests that the personality characteristics associated with the clinical scales will be palpable and robust. In some cases, the low K score can point to exaggeration and a “cry for help,” especially in highly elevated clinical profiles (clinical scales with a T-score of 80 or above). Early research (Heilbrun, 1961; Smith, 1959; Sweetland & Quay, 1953) suggested that low K scores measured defective personality integration and poor adjustment. When the clinical scales suggest a severe disturbance, low K scores indicate difficulty coping and the need for concrete supportive, nurturing therapeutic help; in such cases, avoid insight therapy initially until clients are stabilized. In the absence of clinical scale elevations, low K scores need not reflect emotional disturbance but, rather, emotional directness and a lack of regard for social niceties. Individuals with low K scores tend to disregard or rise above others' judgments about their emotional expressiveness.

Lifestyle and Family Background

Lower K elevations are associated with lower educational levels and lower emotional sophistication. The lifestyle of people with low scores on K tends to be one in which emotions and stress are likely to cause disruptions in efficiency and productivity. In the absence of any elevations on the clinical scales, however, the low K could reflect open, emotionally spontaneous, and uninhibited individuals. Typically, the lower the K, the more likely it is that the person feels she or he is at the mercy of the emotional states revealed by her or his clinical scale scores, and this may be associated with family backgrounds of emotional disturbance and trauma. However, this kind of disturbance and possible family background would be revealed by the clinical scale elevations and a comprehensive history.

Modifying Scales

■ When the Dissimulation (Ds) and Infrequency Psychopathology (Fp) scales are elevated above T-scores of 80 and 100, and the F scale is above a T-score of 85, the low K would confirm a pattern of exaggeration. ■ When the clinical scales are below a T-score of 65 and the F score is below a T-score of 65, the low K may reflect a brash emotional directness. ■ When the Ego Strength scale is elevated above a T-score of 65, the low K may reflect individuals who are unencumbered by restrictions of social appropriateness and are unusually comfortable with emotional spontaneity.

Therapy and Therapeutic Pitfalls

In the presence of elevations on the clinical scales, a low K score would suggest a need for immediate, concrete support and ego strength-building exercises. Self-soothing and thought-stopping to deal with the emotional turmoil associated with clinical scale elevations are recommended. In the presence of a severe disturbance, a low K, combined with an Ego Strength (Es) scale that is below a T-score of 40, may indicate a collapse of ego defenses, so insight therapy is contraindicated. In such cases, suicide threats and the possibility of even minor stress being disorganizing should be considered.

Feedback Statements—low t-score Profiles

Typically, the descriptors and feedback statements associated with elevations on the clinical scales will supersede the following. Some of these feedback statements could be used to supplement feedback from the clinical code-type scales. These statements are also not appropriate if the clinical scales are all below a T-score of 60.

Underregulated

Your profile suggests that you wear your feelings on your sleeve and that you are easy to read as far as emotions are concerned. If you're feeling upset, angry, or happy, others can easily see it. At the same time, if you're feeling angry or upset, the intensity of your emotions may be seen by others as excessive or inappropriate.

Easily overwhelmed

Currently, you may be feeling overwhelmed emotionally so that your feelings overpower you and make it hard for you to function effectively. When stress arises, it may disorganize you so that you find it hard to be effective and get much done. The intensity of your emotions may even frighten you.

Self-doubting or Self-Critical

Because you feel so knocked off balance, you may doubt yourself and, therefore, have difficulty making decisions or demands on others. It's hard for you to trust what you're feeling and what you're thinking. You tend to be your own worst critic, and you're always observing yourself from a very critical standpoint.

Anxious or Fearful

Some of your thoughts may frighten you, and you may find it hard to "switch them off," even though you try to do so. Currently, you may find yourself always on edge, anxious, and fearful that something bad is going to happen.

Direct or nondefensive

People with your profile find it hard to control what they're thinking and feeling so they tend to be direct and even blunt, which sometimes may backfire. The way you approached the test shows that you are very open and nondefensive, willing to talk about what you're feeling.

Treatment and Self-Help Suggestions

1. Find ways to switch off your mind; perhaps learn to meditate so that you can have moments where you do not feel overwhelmed. 2. Every evening, write down a list of a few things you want to get done the next day. When you wake up, begin to work on your list so that you feel some sense of accomplishment. A list will help you feel like you have some control over your thinking and behavior. 3. Learning various types of intentional relaxation can help calm your automatic reactions to stressful situations. One type of relaxation, diaphragmatic breathing, exerts a powerful effect on your physical response to stress. When you feel stressed your breathing is rapid and shallow, but this exercise can calm the automatic response of your nervous system and reduce reactive thinking and destructive emotions. Work with your therapist to learn the diaphragmatic breathing, practice twice daily for 2 weeks, and then continue to practice on a regular basis.

Normal-Range Feedback (T-Score 45 to 65)

Your score on this scale is in the normal range. This score reflects that you answered the questions openly without trying to be too self-critical. Your approach was honest and accurate to the best of your abilities. You are likely to be self-reliant and enterprising and to have good coping skills. You have a wide range of interests and adequate resources. We appreciate your willingness to make yourself vulnerable to this process.

[F-K – Dissimulation Index](#)

a. F-K index is usually used to detect malingering, but the data do not necessarily support its use

1. consistently is the weakest predictor of malingering
 2. continues to be used probably due to clinical folklore
- b. **F-K > 9** suggests an invalid protocol due to symptom exaggeration (faking bad)
- c. **F-K < -9** suggests an invalid protocol due to symptom minimization/ defensive responding (faking good)
- d. some folks argue that you need to use a higher cutoff for a forensic population (e.g., 15 & -15 rather than 9 & -9)
- e. others split the difference and go with 12
1. I argue that a conservative approach would be to use 12 as the cutoff
- e. F-K Index may not be valid with the MMPI-2 (and some authors argue that you should not use it with the MMPI2)
1. because the F scale was decreased by 4 points and the K scale remained the same

Item Response Inconsistency Scales: **TRIN** and **VRIN**

- a. each of these scales suggests that the client is not consistent in his/her answers or approach to the test

TRIN

1. is sensitive to people who have a tendency to answer either true or false without careful consideration of how the question was asked
2. **T-Score > 80**
 - a) indicates an inconsistent responding to the items
 - b) client has a tendency to respond either true or false when pressed
 - c) the scale allows you to check the direction of the responses
3. **T-Score 70-79**
 - a) is suspect and suggests a response set
4. a high K Scale T-Score with a high Basic Scale T-Score and a low Raw TRIN score can be an indication that:
 - a) client was mostly answering false on the test
 - b) may not be psychopathology; just answering false

VRIN

1. reflects a general **tendency to disregard item content in the answers**
2. **T-Scores > 80 indicate:**
 - a) inconsistent random responding; invalid protocol
3. **T-Scores 70-79 indicate:**
 - a) possible invalid protocol due to inconsistent responding

The S Scale

(Superlative Self-Presentation)

- a. developed by Butcher and Han to assess defensiveness
 - b. 5 subscales based on item content that point to possible reasons for defensive attitudes:
 - 1. S1: Beliefs in Human Goodness
 - 2. S2: Serenity
 - 3. S3: Contentment with Life
 - 4. S4: Patience/Denial of Irritability
 - 5. S5: Denial of Moral Flaws
-

Descriptors

Complaints none (superlative adjustment is being claimed)

Thoughts Coherent, rational, or logical; belief in people's goodness

Emotions serene, content, controlled or poised

Traits and Behaviors poised, controlled, resilient, trusting, unflappable

Strengths serene, content, controlled or poised, solid values

Therapist Notes

The Superlative (S) scale was developed as an adjunct to the Correction (K) scale to assess the tendency to present oneself in an overly favorable manner. Although the K scale appears to function effectively as a measure of unconscious self-deception, the presence of a large sample of online pilot applicants allowed Butcher and Han (1995) to compare the response of pilot applicants with the MMPI-2 normative sample. In this group of all-male, mostly Caucasian, and college-educated pilots, their MMPI-2 protocols were relatively normal and, as a group, they tended to report few psychological symptoms and disturbing behaviors. They generally saw themselves as calm, emotionally stable, reasonable people with a clear value system; they reported feeling content with life and generally untroubled by irritability, anger, and conflict with others. The S scale thus acts as a "super" K scale, with which it is highly correlated. It is unlikely, therefore, that individuals scoring low on the K scale will score high on S. As S exceeds a T-score of 65 or 70, the factor analytically derived S subscales are almost always elevated. As the Content scales are face valid, elevations on the K and S scales suppress content scale elevations. Clinicians find difficulty determining when

high S and K elevations are the result of genuine mental health, poise, and emotional stability, and when they reflect self-deceptive efforts to simulate these characteristics. Some job applicants and individuals undergoing child custody evaluations are genuinely emotionally stable and free of severe symptomatology, whereas others are highly motivated to appear so. For a more complete understanding of the S scale and how to use it with the other supplementary scales to determine validity, see Nichols (2001) and Friedman, Levak, Nichols, and Webb (2001).

Lifestyle and Family Background

When S scale elevations reflect a genuine self-presentation, then, typically, high scorers tend to come from stable and psychologically well-balanced backgrounds. As evidenced in the 274 male airline pilot applicants, lifestyles that reflect discipline, order, the pursuit of goals, and a general calm and controlled demeanor are associated with S scale elevations.

Modifying Scales

Elevations on other scales can determine the source of S scale variance.

- When the Lie scale (L) is also elevated, it would suggest that they are rigid, self-righteous, and judgmental. They are presenting themselves as moral and ethical. This would confirm the repressed and inhibited qualities already associated with high S scales.
- When Naïveté (Pa3) is elevated, it would aggravate the tendency to be moralistically rigid and lacking in insight.
- Given the suppressing effect of high S scores on the content scales, even moderate elevations (T-score 60 or above) on one or more of the content scales would warrant further investigation in that area.

Therapy and Therapeutic Pitfalls

When individuals with a high S score seek therapy, they usually do so on the basis of someone else's complaints about their being emotionally underexpressive. Should they find themselves in situations where emotional expressiveness and connectedness is valued, they may experience difficulties. Teaching them to identify and label emotional states and to learn to be more open and responsive to others' feelings could be an important therapeutic goal in helping them in their relationships. Avoid too much emotionality and catharsis in the initial stages of therapy as they may find this threatening.

Feedback Statements (T-Score > 65) rational or logical

People with your profile tend to be clear-thinking, logical, rational, analytical, and not easily knocked off balance by emotions.

Belief in People's goodness

You generally see people as decent and trustworthy. When you meet new people, you give them the benefit of the doubt, and you tend to trust others as being like yourself: reasonable and reliable.

Moral

It is important for you to be seen as someone with strong values, and you want others to see you as doing the right thing. Following the rules is an important part of your self-image.

Content

You are likely to come across as content and happy, feeling that your life is on track, balanced, and going the way you would like it to go. While you may be dissatisfied in certain areas, generally your profile suggests that you are quite content with the direction of your life, and you see life as generally rewarding.

Controlled or Poised

People see you as keeping good control over your impulses and as being in control of your life. People likely see you as poised and sophisticated, able to get what you want in a logical, rational way.

Lifestyle and Family Background Feedback

Typically, people with your profile do not seek psychotherapy unless others see them as somewhat hard to read or emotionally unavailable.

Psychologically you are like a pilot able to fly in heavy weather without becoming knocked off balance. If you are seeking help it may be because you are seen as emotionally distant or aloof by somebody you care about. People may see your contentment and unflappability as being emotionally distant, or they may view your coolness under pressure as a lack of emotional involvement.

Treatment and Self-Help Suggestions

1. Practice recognizing what you are feeling. Take a moment during the day at different times to pay attention to these sensations. See if you can attach a label to the experience, and then find opportunities to talk about how you are feeling with those closest to you.
2. Familiarize yourself with the benefits of "emotional intelligence," which is the ability to identify, assess, and relate to other's emotions in a healthy way. There are many good self-help books written about developing emotional intelligence to make improvements in both your personal life

and in the workplace.^{1 3}. In many ways your coolness under pressure and your ability to see the positives in life is a sign of mental health and resiliency.

Normal-Range Feedback (T-Score 50 to 65)

Your scores on this scale were in the average range. This indicates to us that you took the test in an open and honest manner. You endorsed the items accurately and presented yourself in a nondefensive light. These scores also suggest that you are generally free of debilitating emotional stress and have few unusual symptoms or behaviors.

Clinical Scales

- o Development; to assure that T scores have same meaning across scales

- o Percentile Equivalents

- 30 - <1

- 35 - 4

- 40 - 15

- 45 - 34

- 50 - 55

- 60 - 85

- 65 - 92

- 70 - 96

- 75 - 98

- 80 - >99

- o High scores – T>65

- o Do not interpret low scores

Heterogeneity of Scales

- o Consider descriptors as tentative

- o Determine which descriptors to emphasize

- Harris---Lingoes subscales
- Content and Content Component scales
- Restructured Clinical (RC) scales

Interpretive Tables

- o Based on MMPI and MMPI---2 literature
- o Descriptors for moderate elevations also apply to higher scores
- o Same interpretation for men and women on most scales
- o Pathology and personality descriptors at very high levels; only personality descriptors at moderately high levels.

01 – Hs – *Hypochondriasis*

Scale 1 (Hs)



Summary Descriptive Features of *Hs*

Number of Items: 32

True/False Balance: 11/21

Overlap: 23 items with *HEA*, 20 with Scale 3 (13 on *Hy4*) and *RC1*, 9 with Scale 2, and 4 with Scale 8.

Content: Somatic Complaints. Items reflect head and sensory complaints; poor general health; upper gastrointestinal complaints; weakness, tiredness, and easy fatigability; and cardiac complaints. Specific complaints or symptoms exceed vague complaints in a ratio of about 2:1.

Relations with Other Scales: Among the basic clinical scales, Scale 1 is most highly correlated with Scale 2 at .82 and Scale 3 at .80. The latter correlation is decreased with the addition of the .5K that is added to Scale 1. Correlations with subscales are, in descending order, *Hy-O* (.96), *Hy4* (.94), *Hy3* (.88), *D-O* (.86), *D3* (.82), *D1* (.80), *Sc6* (.80), and *D4* (.79). Scale 1 is also correlated in the mid-.90s with *HEA* (36 items) and *RC1* (27 items). Scale 1 correlations with the *HEA* component scales are: *HEA2* (.87), *HEA3* (.81), and *HEA1* (.80). High raw (i.e., uncorrected by *K*) scores will tend to raise Scales 2, 3, 7, and 8.

Scale 1 is a straightforward scale which measures the number of bodily complaints claimed by a person and whether these complaints are used to manipulate others. This scale does not distinguish actual from imagined physical difficulties.

When the T-score of the scale is below 45, the person is generally seen as an alert, capable person who tends to deny bodily complaints. This T-score is the normal level of the scale for persons in the medical profession and related

areas (nurses, physical therapists, etc.). Others who also may receive a scale score at this level are the children of those in the medical profession, the children of hypochondriacs, and student nurses. These people have been around illness a lot and have seen others use it as a manipulative device. They do not wish to be classified with these manipulators, and therefore, they deny they have illnesses and tend not to seek medical help in the early stages of real somatic complaints.

In recent years we have been seeing people with low scale 1 scores who do not fit the above categories. For these people, what seems to be the common reason for the low scores is that they have negative feelings toward illness and see it as a sign of some weakness. Frequently, joggers and health food enthusiasts score in this range.

Most people score in the 45 through 60 range on this scale which indicates they have the usual number of physical complaints. T-scores of 60 through 70 are common for person who are physically handicapped. Persons with this elevation who do not have such a physical disability may be suffering from a cold or flu and thus may be feeling slightly "under the weather."

As the elevation on this scale increases, and it is the highest scale elevated, people tend to use bodily complaints (either real or imagined) to avoid dealing with psychological difficulties and to manipulate those around them. When the manipulation does not work, particularly with physicians and counselors, clients may shop around until a physician or counselor is found who can be manipulated. Thus, the higher the elevation, the less likely the person is to stay in productive counseling.

When this scale is elevated above 70 and is not the highest scale, it may indicate that the person is having physical problems related to the emotion or behavior shown by the highest scale. For example, if the 7 scale is the highest scale and the 1 scale also is elevated but lower than the 7 scale, the person would be having physical problems that he/she most likely would see as the result of the high anxiety that is present.

Kunce and Anderson (1976, 1984) posit that the underlying dimension on this scale is conservation. When the characteristics measured by a scale 1 are working in the positive direction as shown by a moderate elevation (60-70) in a psychologically normal person, the individual will be conscientious, careful, considerate, and sincere. These individuals seem to be unusually responsive to their environment and tune not only into changes in their bodies but also into the immediate environment around them, e.g., heat and light. A person with a moderate elevation thus may be interested in both personal health and ecological problems. Even in a person who is otherwise well adjusted, stress may turn these positive characteristics into transitory irritability, dependence, and bodily preoccupations.

When scale 1 is moderately elevated along with scale 3 and scale 2 is relatively low Hovey and Lewis (1967) have found the following traits: the individual is socially skillful, confident, fluent, talkative, and relatively free of depression and tensions. In addition the person is quite open to others about what he/she is thinking.

Elevations above 70 on scale 1 are rare in college population but are found frequently in mental health clinic populations. We have found about 10% of the people in our mental health clinic populations scoring above 70 on this scale. This elevation is more likely to be on a man's profile than a woman's. However, when either one has an elevation on this scale and it is the highest scale, it usually indicates behavior of longstanding.

Scale 1: Hypochondriasis (Hs)

Hs was the first scale to be published on the MMPI, primarily because of the large numbers of patients with this disorder that were available, and because the diagnosis was relatively easy to establish (McKinley and Hathaway, 1940). *Hs* measures the number of bodily complaints or somatic ailments claimed by an individual or, said another way, the degree to which a person is denying good physical health. Hypochondriasis is a disturbance involving an unrealistic interpretation of physical signs or sensations as abnormal, which leads the person to fear that he or she has a serious disease (American Psychiatric Association, 2013). The criterion group consisted of 50 inpatients with only pure, uncomplicated hypochondriasis. Patients with other coexisting disorders, like a psychosis or other physical disease, were excluded from the criterion group. Several revisions of the scale were required before it could satisfactorily make discriminations. After the criterion group was selected, the next step in the construction of the scale was to gather the normal comparisons. Various samples within the normal group used in constructing Scale 1 were also used in the construction of the remaining basic clinical scales. The first sample consisted of 109 men and 153 women of the 724 Minnesota normals, ranging in age from 26 to 43, who were visitors at the University of Minnesota Hospitals. As noted earlier (Chapter 1), participants were eliminated if they were currently under the care of a physician. The second normal sample consisted of 265 (151 men; 114 women) unmarried entering freshmen who were receiving precollege guidance counseling at the University of Minnesota Testing Bureau. Unfortunately, more is known about the demographics of the normals used in constructing Scale 1 than for the criterion participants, whose gender proportions and other information is unreported. McKinley and Hathaway (1940), however, did state that participants "were deleted, however, to exclude the extremes of age or other obviously disturbing influences" (p. 256).

The empirical method was primarily used to identify items that discriminated the normals and physically ill people from the 50 patients in the hypochondriasis criterion group. An item was considered for inclusion on the

scale if the normals and patients in the criterion group differed in the frequency of response to the item by at least twice the standard error of the proportions of true-false responses of the two groups (Greene, 2011). However, McKinley and Hathaway (1940) did reject a few of the items on a non-empirical basis if they thought the item drifted too far from the construct of hypochondriasis.

An initial version of the scale consisted of 55 items, but it required further refinement because of the high numbers of psychiatric patients without clinically observed hypochondriasis who also obtained significant Scale 1 elevations. To correct for this occurrence, 50 psychiatric patients without hypochondriacal complaints, but with high scores on the initial version of Scale 1, were compared with the criterion hypochondriacs. Items that discriminated these two groups became known as the Correction for Hypochondriasis (CH) scale. The CH scale consisted of 48 items. Experimentation with the CH items by assigning them different weights failed to improve the performance of the scale. Ultimately, the maximum discrimination was achieved when CH was subtracted from the preliminary *Hs*. As Greene (2011) described it, “for each of these correction items that an individual answered in the non-hypochondriacal direction, one point was subtracted from the total score on Scale 1” (p. 8). Cross-validation with the *CH* scale reliably separated normals from hypochondriacal patients. The hospitalized medical sample demonstrated that the presence of physical disease did not significantly raise scores on the scale.

A final version of Scale 1 occurred when McKinley and Hathaway attempted to improve the separation between Scales 1 and 3. Many correction items were dropped, as were original Scale 1 items that did not stand up on further analysis. The addition of 0.5 *K* helped to improve the ability of *Hs* to make accurate diagnostic discriminations, and commercially available profile sheets provide a space to add the 0.5 *K* value to Scale 1. The final scale consisted of 33 items related to various aspects of bodily functions, including generalized aches and pains, and concerns about different body regions. The re-standardization leading to MMPI-2 prompted the omission of one objectionable item, the modification of three items for grammatical clarification (e.g. tense), the modernization of one item for idiom or usage, and the simplification of one item. The content of the scale is considered obvious, with no subtle items, meaning that an individual wishing to deny good health can readily do so. Given its face validity, Wiener and Harmon chose not to propose S–O subscales for *Hs*. Likewise, Harris and Lingoes (1955) did not discover enough item heterogeneity to form subscales. As Greene (2011) noted, factor analyses of *Hs* in several different populations have consistently identified poor physical health and gastrointestinal difficulties as the two major factors in this scale. More generally, the items on the scale reflect head and sensory complaints, poor appetite, poor general health, upper gastrointestinal complaints, weakness, tiredness, easy fatigability, and cardiac complaints. As Nichols (2011) points out, specific complaints or symptoms exceed vague complaints on a ratio of about 2:1. The deviant direction for 66 percent (21 of 32 items) of the items is False. Therefore, a False response set tends to elevate the scale. Most items on Scale 1 overlap the other neurotic scales, *D* and *Hy*. Only four items overlap Scale 8 (Schizophrenia); one item overlaps Scale 6 (Paranoia). Twenty of the 32 items on Scale 1 are also scored on Scale 3 (*Hy*); thus an elevated score on either scale tends to raise the other. Only eight items are unique (non-overlapping) to Scale 1. (See Table 5.2 for a description of the overlapping content for Scale 1 and the other clinical scales.) Greene (2011) stated that the construct validity of Scale 1 is supported by the fact that Wiggins’ (1966) Poor Health and Organic Symptoms content scales from the MMPI have 12 and 18 items in common, respectively, with MMPI-2 *Hs*. The MMPI-2 Health Concerns content scale (HEA; Butcher, Graham, Williams, & Ben-Porath, 1990) shares 23 of its 36 items with Scale 1.

Increasing elevations on Scale 1 correspond to increasing bodily complaints. Neurotic individuals with bodily preoccupations tend to endorse a diffuse set of bodily complaints, whereas actually ill patients without psychological disturbance contain their item endorsements to the specific physical areas concerning them. Greene (2011) reported that physically ill patients usually obtain only moderate *T*-score elevations between 55 and 60. Patients with actual physical illness who are distressed are more likely to elevate Scale 2 (Depression) than Scale 1.

The normals in the re-standardization sample averaged a raw score of approximately five and six for men and women, respectively, on Scale 1. As normal people age, their Scale 1 scores tend to increase only slightly, approximately two to three items over the life span (Colligan et al., 1989), and five to six *T*-scores in clinical clients, as reported in Greene (2011) using a large sample from Alex Caldwell's (2007b) data base. Regarding education and Scale 1 scores, Greene reported that in both normal and clinical patients, scores on Scale 1 increase five to ten *T*-scores as the number of years of education decrease. Scale 1 elevations have also been noted to occur in chronic pain patients (who also elevate Scale 3) and have been associated with high post-treatment pain intensity and a failure to return to normal activity levels (Prokop, 1988). Generally, a high elevation on Scale 1 is a negative predictor of treatment response (Prokop, 1988). If the clinician sees an excessively low Scale 1 score, such as a raw score of zero, interpretation can range from the individual simply being unusually free of bodily complaints and concerns to being pathologically unconcerned with or unaware of his or her bodily functions. The lack of psychological-mindedness so often cited with high scores on this scale has been seen in a few rare cases with unusually low *Hs* raw scores. Such scores may also indicate the denial of any physical problems because of a counterphobic defense. When examining Scale 1 in a profile, it is important to note the amount of *K* added. Because 0.5 *K* is added to Scale 1, a person may have important hypochondriacal concerns, despite a non-elevated score, because of a low *K* value.

Although some MMPI experts consider that Scale 1 elevations may reflect transient symptoms, such as the flu or a cold (Duckworth, 1979), it is generally considered a stable scale, with test-retest coefficients for psychiatric cases ranging from .79 to .86 for up to a two-week period and from .38 to .65 for a one-year interval (Dahlstrom et al., 1975). Hunsley et al.'s (1988) large-scale meta-analysis of MMPI reliability studies in a wide variety of populations conducted between 1970 and 1981 found an average internal consistency of .79 across 70 studies. They also reported an average test-retest reliability of .78 for 16 studies, with time intervals from one day to two years. Butcher et al. (2001) reported reliability data for a subset of the re-standardization sample that included 82 normal men and 111 normal women retested at an average interval of 8.5 days (*Mdn* = 7 days), and found test-retest correlations for men and women of .76 and .74, respectively, again illustrating the stability or characterologic nature of the scale. Internal consistency estimates (Cronbach's coefficient alpha) of .77 and .81 were reported for men and women, respectively.

SCALE 1: HYPOCHONDRIASIS (*Hs*)

Development

Hypochondriasis was the first of the basic scales to be developed because there was widespread agreement on the construct, which was fairly simple, and because many cases were available for study. The criterion group for Scale 1 consisted of 50 cases manifesting "abnormal . . . concern over bodily health" (McKinley & Hathaway, 1940/2000, p. 7) and carrying a diagnosis of Psychoneurosis, Hypochondriasis. The cases were carefully selected to exclude patients with symptoms of psychosis, and all had been thoroughly screened to exclude medical, neurological, or other psychiatric illness. The items that discriminated between this group and two comparison groups (262 [109 men, 153 women] of the 724 Minnesota Normals who had been roughly matched to the criterion group for age, and 265 [151 men, 114 women] students entering college) were gathered into a preliminary scale that was then tested against two other groups: 50 patients who were hospitalized on medical wards of the university hospital for physical illness, and 45 patients hospitalized for psychiatric treatment for conditions other than hypochondriasis. These procedures reduced the influence on scale scores of demographic variables such as age, marital and socioeconomic status, and education, and tested the ability of the scale to discriminate hypochondriacs from

other patients with whom they might be confused, whether medical patients suffering the pain, discomfort, inconvenience, and stress of organic disease (and hospitalization) or psychiatric patients who may manifest hypochondriacal features in the context of other psychiatric disorders. The scale was cross-validated on a new sample of 25 hypochondriacs, and these cases separated themselves adequately from the normal, medical, and psychiatric samples.

Interpretive Implications

General

Concerns center on health and somatic functioning. These concerns tend to persist despite disconfirming medical opinion and negative findings from diagnostic procedures, with the latter bringing not relief but a continued conviction of illness and decreased confidence in the physician who ordered them. Patients with bona fide illnesses generally score near *T*-60, but they may obtain scores that are considerably higher if the illness is life-threatening and/or engenders fear and anxiety. Scores on Scale 1 never rule out a disease or illness of medical significance. (See Rapid Reference 6.1 for a summary description of Scale 1.)

- 1) 32 items which focus on **bodily concerns with a physiological basis or individuals who exaggerate bodily concerns**
 - a. *Examples: 53. Parts of my body often have feelings like burning, tingling, crawling, or like "going to sleep." (T)*
 255. *I do not often notice my ears ringing or buzzing. (F)*
- 2) developed on a group of neurotic patients who showed an excessive concern about their health, presented a variety of somatic complaints with little or no organic basis, and
 - rejected repeated assurances that there was nothing physically wrong with them
- 3) has no associated Harris-Lingoes Scales
- 4) **T-Scores > 65 (marked elevation) are indicative of individuals who:**
 - a. have excessive bodily concerns
 - b. may have conversion disorder or somatic delusions
 1. especially if *T* > 80
 - c. describe somatic complaints that generally are vague
 1. if the somatic complaints are specific, they tend to be epigastric in nature
 - d. complain of chronic weakness, lack of energy, and sleep disturbance
 - e. if medical patients, they may have a strong psychological component to their illness
 - f. are likely to be diagnosed as having somatoform, somatoform pain, depressive, or anxiety disorders
 - g. are not likely to act out in psychopathic ways
 - h. seem selfish, self-centered, and narcissistic

- i. Have a pessimistic, defeatist, and cynical outlook toward life
- j. are unhappy and dissatisfied
- k. make others miserable
- l. complain
- m. communicate in a whiny manner
- n. are demanding and critical of others
- o. express hostility indirectly
- p. are described as dull, unenthusiastic, and unambitious
- q. lack ease in oral expression
- r. generally do not exhibit much manifest anxiety
- s. seem to have functioned at a reduced level of efficiency for long periods of time
- t. see themselves as medically ill and seek medical treatment
- u. lack insight and resist psychological interpretations
- v. are not very good candidates for psychotherapy or counseling
- w. become critical of their therapist
- x. terminate therapy prematurely when the therapist suggests psychological reasons for symptoms or when the therapists are perceived as not giving enough attention and support

5) T-Scores 58-64 (moderate elevation) are indicative of individuals who:

- a. have some concern about bodily functioning
- b. are likely to be seen as immature, stubborn, and lacking drive
- c. scores in the lower end of this range are typical for individuals with physical handicaps and individuals with actual physical disease

6) Normal range T-Scores 40-57

7) T-Scores < 40 (low scores) are indicative of individuals who:

- a. are free of somatic preoccupation
- b. are alert, sensitive, and insightful
- c. are generally effective in their daily lives
- d. scores in this range are typical of individuals in helping professions

T >75 Extreme and sometimes bizarre somatic concerns; consider somatic delusions; chronic pain

T = 65---74 Somatic complaints, may develop somatic symptoms in times of stress; chronic pain

T=55---64 Somatic complaints; lacks energy, demanding, dissatisfied, complaining, whiny

T=45---54 Average score; no interpretation

T <45 Low score; no interpretation

>80 - somatic delusions

>65 - somatic concerns, vague and epigastric somatic complaints, somatization, pessimism, psychologically naive, narcissism, immaturity, rigidity

58-64 - lesser degree of the above or an actual disorder

38-45 - adequately adjusted, insightful, may appear moralistic and interpersonally detached

<38 - deinvested in their bodies, high risk behaviors

Harris---Lingoes: None

This scale reflects fears and preoccupations about physical functioning and fears of bodily damage. The more elevated the scale, the more intense and consuming the preoccupations, and the more immature, dependent, and lacking in insight the individual. Panic around physical integrity is primitive and pervasive, leaving little room for psychological insight. The lower the scale (below $T=50$), the more the individual will have a tendency to be cavalier about physical illnesses and ailments.

02 - D - *Depression*

Scale 2 (D)

Summary Descriptive Features of *D*

Number of Items: 57

True/False Balance: 20/37

Overlap: 13 items with *INTR*, 12 with Scale 7, 9 with Scale 1 and *DEP*, 8 with Scale 8 (5 with *Sc4*) and *RC2*, 7 with Scale 7, and 5 with *RCd*.

Content: Unhappiness, anxiety and worry, apathy and lethargy, nonimpulsiveness, inhibited aggression, physical symptoms, social withdrawal, and low self-esteem.

Relations with Other Scales: Among the basic clinical scales, Scale 2 is most highly correlated with Scales 1, with which it shares 9 items, at .82, and 7, with which it shares 12 items, at .80. These correlations are decreased with the addition



of .5K to Scale 1 and 1.0K to Scale 7. Correlations with subscales are, in descending order, *D-O* (.95), *DI* (.95), *D4* (.90), *Hy3* (.90), *Hy-O* (.87), *D5* (.82), *Sc4* (.81), and *D3* (.80). Scale 2 is also highly correlated with *RC2* (.82), with the content scale *DEP* (.80), and with its component scales *DEP2* (.79) and *DEP1* (.77), and moderately correlated with *DEP3* (.64) and *DEP4* (.55).

Two observations should be noted in evaluating scale 2. First of all, this is a mood scale. It measures the degree of pessimism and sadness the person feels at the time the MINPI was administered. Thus, a change in mood will lower or raise this scale. Second, scale 2 is rarely elevated by itself; usually at least one or two other scales also are elevated. These other scales can be helpful in determining how the depression is shown.

Most people are below the 60 T-score point on this scale. When the T-score is between 60 and 70, a mild dissatisfaction with life may exist, but either the dissatisfaction is not enough for the person to be really concerned or the dissatisfaction is of long standing and the person has learned to live with it. When the 2 scale is at 60 and the 9 scales at 45, possibly the person took the inventory at the bottom of a mood swing (for example during a post-exam let-down), at the end of a long work day, or when he/she had a cold. In these situations the person's real pattern is usually an elevated scale 9 (T = 60 to 65) and a lowered scale 2 (T = 45 to 55).

As the elevation increases, the person's attitude changes from sadness (T = 70) to gloom (T = 80) to all pervasive pessimism about self and the world (T = 90 or above).

Low scale 2 scores (45 or below) indicate that the person is cheerful, optimistic, and easy going. However, these attitudes should be checked in terms of their appropriateness for the person's situation, particularly if a tragedy has occurred recently.

Kunce and Anderson (1976, 1984) posit evaluation as the underlying dimension on this scale, that is, the person has an inclination for sorting out good from bad, right from wrong. A moderately high elevation on scale 2 (60 to 70) in an individual who has good mental health would indicate a person who is realistic and objective. In addition he/she is likely to be deliberate and contemplative. When placed under stress this same individual will show transitory worry and anxiety with feelings of guilt connected with an overly critical attitude toward his/her own behavior.

Scientists such as mathematicians, physicists, engineers, and chemists tend to have moderately high scores on this scale (Kunze & Ca ills, 1969; Norman & Red lo, 1952) which is consistent with the realistic and objective dimension of this scale. Hovey and Lewis found that when scale 2 is elevated along with 3 these individuals are ambitious, conscientious, industrious, and take responsibilities seriously.

Scale 2 is one of the most frequent high points on a profile for clients in college counseling centers and mental health clinics. It usually indicates a reaction to problems that are pressing on the person. Very rarely is this elevation an indication of chronic depression.

- 1) 57 items reflecting the **feelings of discouragement, pessimism, and hopelessness, as well as the personality features of hyper-responsibility, high personal standards, and intrapunitiveness**

a. *Examples: 127. Criticism or scolding hurts me terribly. (T)*

117. I have never vomited blood or coughed up blood. (T)

142. I have never had a fit or convulsion. (F)

- 2) scale developed on psychiatric patients with various forms of symptomatic depression

- 3) Harris-Lingoes Scales:

- a. subjective depression
- b. psychomotor retardation
- c. physical malfunctioning
- d. mental dullness
- e. brooding

- 4) **T-Scores > 65 (marked elevation) are indicative of individuals who:**

- a. display depressive symptoms
 1. especially if T-Score > 70
- b. feel blue, unhappy, and dysphoric
- c. are quite pessimistic about the future
- d. have self-deprecatory and guilt feelings
- e. may cry, refuse to speak, and show psychomotor retardation
- f. often are given depressive diagnoses
- g. report bad dreams, physical complaints, fatigue, weakness, and loss of energy
- h. are agitated and tense
- i. Are described as irritable, high-strung, and prone to worry and fretting
- j. lack self-confidence
- k. feel useless and unable to function

- l. give up easily
- m. feel like failures in school and work
- n. have lifestyles characterized by withdrawal and lack of involvement with other people
- o. are introverted, shy, retiring, timid, seclusive, and secretive
- p. are aloof and maintain psychological distance from others
- q. have a restricted range of interests
- r. withdraw from activities in which they previously participated
- s. are very cautious and conventional
- t. have difficulty making decisions
- u. feel overwhelmed when faced with major life decisions
- v. are overcontrolled and deny their own impulses
- w. avoid unpleasantness and make concessions to avoid confrontations
- x. because of high personal distress, are likely to be good candidates for psychotherapy and counseling
- y. may terminate therapy when the immediate crisis is over

5) **T-Scores 58-64 (moderate elevation) are indicative of individuals who:**

- a. are dissatisfied with something or with themselves but may not recognize this state as depression
 - i. mild degree of depression may not appropriately represent the situation
- b. may not be overly concerned about what is happening to them
- c. may have learned to adjust to a chronically depressed existence

6) Normal range: **T-Score 40-57**

7) **T-Scores < 40 (low scores) are indicative of individuals who:**

- a. do not experience much tension, anxiety, guilt, or depression
- b. feel relaxed and at ease
- c. are self-confident
- d. are emotionally stable and capable of effective functioning in most situations
- e. feel cheerful and optimistic
- f. have little difficulty in verbal expression
- g. are alert, active, and energetic
- h. are competitive and seek out additional responsibilities
 - i. Are at ease in social situations
- j. seek out leadership roles

- k. create favorable first impressions
- l. are seen as clever, witty, and colorful
- m. may be impulsive and undercontrolled
- n. are show-offish and exhibitionistic
- o. may arouse hostility and resentment in other people

T >75 Serious clinical depression; suicidal ideation; feelings of unworthiness and inadequacy

T = 65---74 Moderate depression, worried, somatic complaints

T = 55---64 Dissatisfied with life situation; introverted, withdrawn; restricted range of interests; lacking in self-confidence

T = 45---54 Average score; no interpretation

T <45 Low score; no interpretation

>80 - check for suicidal ideation, severe depression

75-85 - moderate depression, 65-75 – mild unhappy, low self-esteem, helplessness, hopelessness - depression, withdrawal, psychomotor retardation

Norm - comfortable, gregarious, active, alert, enthusiastic

Very low - lack of impulse control, conflict with societal values, manic state

Scale 2 is one of the most frequently elevated scales in clinical populations and is usually elevated together with other scales. Scale 2 is sensitive to current mood, so a grief reaction could be reflected in a Scale 2 elevation without necessarily indicating a serious depression or mood disorder. Thus, interpretation of Scale 2 elevations depends on the configuration of the rest of the profile and the clinical history. Scale 2 increases somewhat with age, perhaps reflecting pessimism about the future or the accumulation of unresolved losses. Research on optimism by Seligman (1990) and others, however, suggests that some people appear to be genetically resistant to depression, exhibiting a remarkable resilience or hardiness in the face of loss, staying positive despite setbacks and failures. Such individuals would likely exhibit low scores on Scale 2.

High scores ($T > 65$) on Scale 2 reflect people who are depressed, anxious, worried, experience low self-esteem, and are pessimistic in their outlook. Typically, they show a narrowing of interests, poor morale, and in some cases expressed irritability. They generally feel discouraged, sad, useless, and guilty. Sleep difficulty, low energy,

diminished appetite and sex drive, and difficulties with memory and concentration are typical. The higher Scale 2 is above T -65, the more depressed and self-deprecating the person is likely to be. Scores above T -80 suggest a severe depression with more extreme symptoms and a marked decline in self-management and general efficiency.

Normal range, slightly elevated Scale 2 (T -55–65) scores suggest individuals who are somewhat inhibited, serious, and introspective, with a tendency to take setbacks badly and with a quickness to feel guilty or self-blaming when things go wrong. They tend to lack self-confidence and to be acquiescent and passive in the face of conflict.

Generally they are responsible, analytical, dutiful people who avoid risk.

Moderately low to very low scores ($T < 45$), if no other scales are elevated, suggest alertness, cheerfulness, buoyancy, self-confidence, and a good sense of humor. These individuals are seen as enthusiastic and socially outgoing, particularly if Scale 0 is low. In some people, however, a low Scale 2 score can also indicate a lack of inhibition and perhaps even impulsiveness, especially if Scale 9 is elevated, the K scale is low, and/or Scale 4 is mildly elevated. In some cases, when Scale 9 is elevated above a T -score of 65 and Scale 2 is below a T -score of 45, the low Scale 2 score may be reflecting a bipolar individual currently in a manic phase. Treatment for depression includes medication, CBT, venting emotions and catharsis about past losses, and self-esteem building.

Scale 2: Depression (D)

Scale 2 (D) was designed to measure the presence and depth of symptomatic depression, a mood state characterized by low morale, feelings of hopelessness or worthlessness, slowing of thought and action, and occasional preoccupations with death and suicide (Dahlstrom et al., 1972). D is considered to be a mood scale (state vs. trait) and is therefore sensitive to transient and even very brief emotional states, including diminished morale and efficiency. For this reason, it is useful in measuring response to treatment. Scale 2 can be considered “an index of how comfortable and secure clients feel about themselves and their environment, with higher scores indicating dissatisfaction” (Greene, 2011, p. 110). In fact, the scale is generally more sensitive to bona fide health/illness states than Scale 1 scores (Nichols, 2011).

Scale 2 is the most frequently elevated scale in the MMPI-2 and the most frequent high point in adult psychiatric populations (Nichols, 1988). In adolescent patients, Scale 2 appears second only to Scale 4 (Psychopathic Deviate) in high-point frequency on the MMPI (Marks et al., 1974).

Using a large clinical sample from Caldwell (2007a), Greene (2011) listed 15 MMPI-2 scales with the highest correlations with D . He then organized these scales into four general categories: (1) symptoms of depression and anxiety; (2) fatigue and lack of energy; (3) general subjective distress and negative affect; and (4) poor physical health

and multiple physical symptoms. Nichols (2009) has developed a revised set of subscales for Scale 2 described in the next section on the Harris-Lingoes subscales. Five participant groups were used to construct *D*.

However, most of the 60 items contained on the original scale were derived by comparing normals (i.e. participants without observable depression) with a group of 50 patients who were carefully diagnosed as being in the depressed phase of a manic-depressive psychosis (Hathaway & McKinley, 1942). Because some non-depressed participants obtained elevated scores, a correction factor was derived (as was done in the construction of Scale 1) by comparing item endorsement patterns of 40 normals, who earned elevated scores on an early version of the Depression scale, with a group of 50 patients without observable depressive signs but who also scored high. Eleven items differentiating the two groups became correction items that were included in the final scale. A depressed normal group was also used in the derivation of the scale “to help establish the meaning of more intermediate scale values between the normal and criterion groups, which would have been impossible if only the two extreme groups were contrasted” (Greene, 2011, p. 109). Hathaway and McKinley (1940, as cited in Dahlstrom & Dahlstrom, 1980, p. 26) described the final selection of *D* items in the following way:

First, each depressive item had to show a progressive increase in frequency from the normal groups through the depressed normal group to the criterion group since it was assumed that the depressed normals would be less than the criterion cases but more than the general normals. In all items primarily indicating depression, the difference in percentage between the normal and the criterion was 2.5 or more times its standard error.

Second, the non-depressed group percentage for the item was required to approach that for normals. After careful analysis of all percentages for each of the 504 items, 60 items were chosen as the final depression scale. Although the criterion group for Scale 2 consisted of individuals afflicted with a severe depressive illness characterized as psychotic, Hathaway and McKinley considered depression to be the cardinal feature of their disturbance. Dahlstrom et al. (1972, p. 187) stated that although the scale was devised on a largely psychotic group of patients, it became clear in the early research that the items reflected depressive mood changes on a neurotic basis—in fact, any depressive reaction, no matter what the underlying character structure or adjustment status of a patient might be.

Greene (2011) stated that Scale 2 is sensitive to, but not specific to, depressive mood disorders. This explains why *D* is so often elevated in profiles where depression may not be the primary diagnosis, but is prominent in understanding the client.

The original MMPI *D* had 60 items, but the revision leading to the MMPI-2 deleted 3 items pertaining to religious matters. The resulting 57-item MMPI-2 scale also underwent modifications on 2 items, one to eliminate sexist wording and one to modernize usage. Approximately two thirds of the items are keyed False (37 False; 20 True). The All-False response set will therefore inflate Scale 2 scores, as well as the other scales in the neurotic triad (Scales 1, 2, and 3). Scale 2 shares 47 of its 57 items fairly evenly with the other clinical scales (Dahlstrom et al., 1972). Only 13 items are unique to the scale. *D* shares only 10 items with the MMPI-2 *DEP* content scale. These two scales measure different aspects of depressive symptoms, so they should not be used interchangeably. Scale 2 shares 13 items with Scales 7 and 9 and 8 items with Scales 1 and 8, respectively. Wiener and Harmon (1946) considered the majority of *D* items obvious. Thirty-nine items are obvious and 18 items are subtle, although the two sets intercorrelate at .80 (Nichols, 2011).

Test-retest reliability data for Scale 2, as reported in the *Manual* (Butcher et al., 2001), were based on 82 normal men and 111 normal women, retested at about one week, which yielded correlations of .79 and .80, respectively. Dahlstrom et al. (1972) reported lower test-retest stability data on clinical groups for MMPI Scale 2, which is expected, given the greater emotional instability of clinical patients. In Hunsley et al.'s (1988) large-scale meta-analysis of MMPI reliability studies using a wide variety of populations conducted between 1970 and 1981, an average test-retest reliability of .78 was reported for 16 studies, with time intervals from one day to two years. Hunsley et al. also reported an average internal consistency of .81 across 74 studies. Internal consistency estimates for *D* derived from the re-standardization sample (Butcher et al., 2001) yielded correlations of .59 and .64 for men and women, respectively.

The 57 *D* items reflect a number of concerns related to depression, including a loss of appetite and energy, distractibility, loss of self-confidence, lack of interest in things, denial of happiness or personal worth, and physical symptoms (e.g. sleep disturbance and gastrointestinal complaints).

In general, as Scale 2 scores elevate into the clinically significant range ($T > 65$), the greater the probability the person is suffering depressive symptoms. Severity is often a function of scale elevation, but it is also reflected in other clinical scale elevations. Rarely is Scale 2 elevated in isolation. Analysis of other clinical scale elevations, as well as the subscales and supplementary scales, helps to determine the quality of the depression. Scale 2 not only reflects the presence and degree of various forms of symptomatic depression but also basic personality features of hyper-

responsibility, high personal standards, and intro-punitiveness, which can predispose an individual to experience depression (Butcher et al., 1989; Dahlstrom et al., 1972). Individuals scoring in the extremely high range ($T \geq 91$) likely have endorsed a wide range of depressive content reflecting severe withdrawal, a dependent state, and serious suicidal risk.

Although several studies have provided correlates for high-scoring psychiatric patients, very low scores ($T < 40$) should not necessarily be interpreted in psychiatric patients as reflecting the converse of depression, such as an active, enthusiastic, optimistic, socially outgoing person. These very-low-score descriptors are more likely to apply to normals than psychiatric patients (Keiller & Graham, 1993). However, Venn (1988) reported pathological correlates in a sample of low-scoring adult men on Scales 2 and 0 (Social Introversion) who took the MMPI as part of employment screening.

Low-scoring participants on both Scales 2 and 0 had indications of probable character pathology (e.g. impulsive behavior and an arrest record). As stated earlier, Keiller and Graham suggested that low scores may have different meanings for psychiatric outpatients and inpatients and that low scores may be more likely associated with unfavorable characteristics in psychiatric samples. Further research on low scores in different samples across settings (e.g. forensic, medical, and employment) is called for in order to understand the generalizability of their findings.

Harris---Lingoes

D1 - Subjective depression - agitation, meaninglessness, insecurity, low self-esteem

D2 - Psychomotor retardation - immobilized, socially avoidant, motorically slow, deny hostility

D3 - Physical malfunctioning - preoccupation with physical symptoms

D4 - Mental dullness - memory/concentration problems, lack of energy, hopelessness, helplessness

D5 - Brooding - ruminative, unable to control intrusive thoughts, irritable, sensitive to criticism, lack meaning

Harris-Lingoes Subscales

The reader is reminded to be alert about the brevity of several of the subscales and to use caution in interpreting subscale scores below a T -score of 70 for all of the Harris-Lingoes subscales. Harris and Lingoes (1955) developed five subscales for the Depression scale on the MMPI, which are identical on the MMPI-2. The five subscales for the *D*are: Subjective Depression (*D1*), Psychomotor Retardation (*D2*), Physical Malfunctioning (*D3*), Mental Dullness (*D4*), and Brooding (*D5*). These subscales are extensively overlapping, Of the 49 items that appear on one of the subscales, 23 appear on two or more, for a total of 55 overlaps. *D1*, for example, overlaps with *D2* (8 items), *D3* (3

items), and *D4* (12 items), and contains all 10 of the *D5* items. Five *D2* items overlap with *D4* and two with *D5*; *D4* and *D5* overlap by four items. (Nichols, 2011, p. 102)

Taken together, the 55 total overlaps among the *D* subscales averages 11 overlaps each which, according to Nichols (2011), is far more than for any of the other Harris-Lingoes sets. Eight (14 percent) of the Scale 2 items appear on none of the subscales. Nichols (2009) created a set of five alternative *D* subscales, named: *Dr1*—Depressed Mood; *Dr2*—Inhibition of Aggression; *Dr3*—Somatic Malaise; *Dr4*—Cognitive Infirmary; and *Dr5*—Social Vulnerability. These subscales have at least two advantages over the original Harris-Lingoes subscales.

First, the number of overlaps has been reduced to six, averaging 1.2 per scale; any given pair of scales average only 0.6 overlapping items (range: 0–3), amounting to 5 percent of the average scale length. Second, each *D* item appears on at least one subscale. A possible disadvantage is that two of the new subscales contain only eight items (vs. a minimum of 10 items for the Harris *D* subscales). (Nichols, 2011, p. 104) The reader interested in obtaining these alternative *D* subscales should contact Nichols.

The five Harris-Lingoes subscales for Scale 2 are extensively overlapping. Of the 49 items that appear on one of the subscales, 23 appear on two or more, for a total of 55 overlaps. *D1*, for example, overlaps with *D2* (8 items), *D3* (3 items), and *D4* (12 items), and contains all 10 of the *D5* items. Five *D2* items overlap with *D4* and two with *D5*; *D4* and *D5* overlap by four items.

Subjective Depression (D1)

T-Scores > 65 are indicative of individuals who:

1. feel unhappy, blue, or depressed most of the time
2. lack the energy to cope with everyday life
3. are not interested in what goes on around them
4. feel nervous or tense much of the time
5. have difficulties concentrating and attending
6. have poor appetite and difficulty sleeping
7. brood and cry frequently
8. lack self-confidence
9. feel inferior and useless
10. are easily hurt by criticism
11. feel uneasy, shy, and embarrassed in social settings
12. tend to avoid interactions except for relatives and close friends

T-Scores < 40 are indicative of individuals who:

1. feel happy and satisfied
2. are interested in and stimulated by their environments
3. deny tension, difficulties in concentration/attention, poor appetite, sleep disturbance, and frequent brooding or crying
4. are self-confident
5. are socially extroverted
6. like to be around other people and are at ease in social situations

D1 (Subjective Depression—32 items):

“A negation of joy in doing things; pessimism, poor morale and low self-esteem; complaints about psychological inertia and lack of energy for coping with problems” (Harris and Lingo). One of the mood components of Scale 2, *DI* appears to operate as an analog of the full *D* scale. It is the longest of the *D* subscales, containing more than half of the *D* items. The items are the most obviously depressive of the Scale 2 items; *DI* is almost completely contained in and virtually identical to *D-O* ($r = .98$). It is highly correlated with *Hy3* (.91), *Sc4* (.89), *Sc3* (.81), *Sc2* (.78), *Pd5* (.79), and MMPI-2 content scales *DEP* (.89; *DEP1* [.86]; *DEP2* [.86]), *ANX* (.86), *WRK* (.85), *TRT* (.79; *TRT1* [.78]), *LSE* (.78; *LSE1* [.79]), *HEA* (.75), *OBS* (.72), and *SOD* (.68), as well as *INTR* (.79) and *NEGE* (.75). *DI* is probably the most sensitive MMPI-2 scale to short-term fluctuations in mood.

D1: Subjective Depression (32 Items)

The longest of the subscales, containing more than half of the *D* items with 17 items scored False direction and 15 scored True, *DI* indicates obvious distress, such as feeling unhappy, pessimistic, suicidal, joyless, worrying; having sleeping, morale, and concentration difficulties; and generally not feeling worthwhile. Other descriptors include feeling easily hurt by criticism and a lack of energy for coping with problems (Caldwell, 1988; Nichols & Greene, 1995). Dysphoria is the mood state typified by this subscale, and diagnoses of depression or dysthymia often accompany elevations on this subscale as well as the other depression subscales (Graham, Ben-Porath, & McNulty, 1999). Caldwell (1988) stated that this subscale captures the “general misery of depression” (p. 16). The worrying aspect of the scale is found in the fact that all 10 of the items on the brooding subscale (*D5*) are contained within *DI*. Wrobel (1992) reported the following correlates to be applicable to high *DI* scorers: pessimism, poor morale, low self-esteem, lack of energy for coping, feelings of psychological inertia, and a lack of joy in doing things. Graham et al. (1999) also reported that high *DI* scorers feel overwhelmed and unable to cope with stress. The reader is referred to Nichols (2011) for an extensive listing of all the Harris-Lingo subscales correlations, with several content and supplementary scales.

Low scorers on this subscale tend not to report a loss of interest, or general depressive feelings. The items are predominantly obvious and *DI* is almost completely contained in and virtually identical to *D-O* (Nichols, 2011). As an analog of Scale 2, *DI* is likely the most sensitive MMPI-2 scale to short-term fluctuations in mood.

Psychomotor Retardation (D2)

T-Scores > 65 are indicative of individuals who:

1. are characterized as immobile and withdrawn
2. lack the energy to cope with everyday activities
3. avoid other people
4. deny hostile or aggressive impulses at times

T-Scores < 40 are indicative of individuals who:

1. describe themselves as active and involved
2. have no difficulty getting started on things
3. view everyday life as interesting and rewarding
4. admit having hostile and aggressive impulses at times

D2 (Psychomotor Retardation—15 items):

“Non-participation in social relations; immobilization” (Harris and Lingo). *D2* is the inhibition component of Scale 2 and only weakly correlates with its contrastingly named

Scale 9 counterpart, *Ma2*, at $-.15$. It is composed of items whose content suggests withdrawal from social participation, lethargy/anergia, and denial of aggression and anger. The inhibitions involved appear to be more emotional than behavioral, judging from correlations with *R* (.52) and *DISC* ($-.32$). *D2* appears to be sensitive to passivity and submissiveness (Friedman et al., 2001).

D2 is moderately correlated with *INTR* (.66). Levitt (1989) has speculated that low scores on *D2* may suggest sufficient energy for suicide, and this would seem to apply especially when scores on the other Scale 2 subscales are high.

D2: Psychomotor Retardation (14 Items)

The items on this subscale reflect inhibited aggression and a lack of energy, vigor, and initiative (Nichols & Greene, 1995). Four of the items are scored True, 10 False. Wrobel (1992) found a low but significant correlation with a lack of participation in social interactions. Harris and Lingo also attributed nonparticipation in social relations and immobilization to elevated scores. Nichols (2011) views *D2* as the inhibition component of Scale 2—it only weakly

correlates with its contrastingly named Scale 9 counterpart, Ma, at $-.15$. According to Nichols (2011), the inhibitions induced appear to be more emotional than behavioral. Psychiatric outpatient women in the Graham et al. (1999) study sample were also described as being not very competitive. Nichols and Greene (1995) suggested that *D2* emphasizes social withdrawal and rigid controls against hostile or aggressive expressions. In essence, this subscale is tapping a dimension of passivity and submissiveness (Friedman et al., 2001). Caldwell (1988) asserted that elevations on *D2* may reflect indecision at least as much as physiologic slowing. This is consistent with the moderate correlation Nichols and Greene report between Mental Dullness (*D4*) and *D2*. Levitt (1989) suggested that a low *D2* score, when other depression indexes are high, may point to a suicide potential, presumably because the person has the energy to act on his or her suicidal feelings. However, Graham et al. (1999) also found that females with high scores on *D2* were described by their therapists as having suicidal ideation.

Physical Malfunctioning (*D3*)

T-Scores > 65 are indicative of individuals who:

1. are preoccupied with their own physical functioning
2. deny good health
3. report a wide variety of specific somatic symptoms that may include weakness, hay fever or asthma, poor appetite, nausea or vomiting, and convulsions

T-Scores < 40 are indicative of individuals who:

1. present themselves as being in good physical health
2. do not report a wide variety of specific somatic

D3 (Physical Malfunctioning—11 items):

“Complaints about physical malfunction; preoccupation with oneself” (Harris and Lingoes). This subscale encompasses the somatic component of Scale 2. Content predictably reflects the vegetative features of depression, such as loss of appetite, change in weight, weakness, and constipation. It may be noteworthy that three of the items (117T, 181T, and 238F) deny somatic problems. *D3* is highly correlated with Scale 1 (.82), *Hy3* (.82), *Hy4* (.72), and *HEA* (.76; *HEA3* [.76]; *HEA1* [.68]; *HEA2* [.67]). Caldwell (1988) speculated that *D3* may touch on the fear that one may never be restored to health, that there is nothing to look forward to but further physical decline.

D3: Physical Malfunctioning (11 Items)

D3 subscale encompasses the somatic component of Scale 2, although Levitt (1989) opined that it contains too few items to be useful clinically. *D3* is highly correlated with Scale 1 (*Hs*), with 7 of its 11 items overlapping Scales 1 and 3. Four of the 11 items on *D3* are keyed True, 7 False. Its content predictably reflects the vegetative features of depression, such as loss of appetite, change in weight, weakness, and constipation (Caldwell, 1988; Nichols, 2011). High scores most likely reflect a preoccupation with oneself (Wrobel, 1992). A sense of feeling unrelieved from one's discomforts and pessimistic about ever feeling well is suggested. Caldwell (1988) speculated the *D3* may touch on the fear that one may never be restored to health, that there is nothing to look forward to but further physical decline; *D3* is probably the most specific indicator of depressive somatization (Nichols & Greene, 1995). It is not surprising that the Lassitude–Malaise subscale (*Hy3*) and *D3* correlate strongly in a group of psychiatric inpatients and outpatients (Nichols & Greene, 1995).

Graham et al. (1999) reported that women psychiatric outpatients were described by their therapists as lacking energy and having a low sex drive. Furthermore, they were described as lacking interest and aspirations. Both men and women who score high on *D3* were seen as having difficulty with concentration although it is interesting to note that concentration difficulties were not generally reported by Graham et al. (1999) for patients scoring high on Mental Dullness (*D4*). Low *D3* scores most likely reflect that the individual does not feel physically handicapped and may, in fact, feel very good.

Mental Dullness (D4)

T-Scores > 65 are indicative of individuals who:

1. lack the energy to cope with the problems of everyday life
2. feel tense
3. complain of memory or judgment difficulties

T-Scores < 40 are indicative of individuals who:

1. view life as interesting and worthwhile
2. feel capable of coping with their problems
3. deny tension
4. deny difficulties in concentration, memory, and judgment

D4 (Mental Dullness—15 items):

“Unresponsiveness; distrust of one’s own psychological functioning” (Harris and Lingoes). *D4* reflects the cognitive debility of depression; it is the mental counterpart of *D3*. The items overlap with those of several other subscales, including *D5* (40%), *Sc3* (40%), and *Sc4* (36%), and describe an inability to comprehend one’s reading, distractibility, lapses in judgment, problems with memory, low energy, a lack of selfconfidence and initiative, and a sense of the futility of caring and trying. It is highly correlated with *D1* (.94), *Sc4* (.90), *Hy3* (.88), and *Sc3* (.87). Eight of its items (53%) overlap with those of Scale 7. High scores imply a loss of interest, a sense of mental failure or decline, and the depletion of energy needed to accomplish mental work. Thinking and problem solving are experienced as effortful and as subject to going off course even when significant effort is made. The patient is likely to view his or her thinking as impaired and unreliable, and to have the sense that “I can’t seem to get my mind to work right.”

D4: Mental Dullness (15 Items)

D4 reflects the cognitive enfeeblement of depression; it is the mental counterpart of *D3*. Eight of the items are keyed True, seven False. High scores imply a loss of interest, a sense of mental failure or decline, and the depletion of energy needed to accomplish mental work (Nichols, 2011). Caldwell (1988) referred to this scale as the “mental fog” (p. 17) of depression. The themes he reported in the subscale consist of: (a) “losing one’s mind,” that is, being easily

distracted, unable to comprehend what one reads, and suffering memory and judgment problems (consistent with Wrobel's, 1992, finding of a distrust of one's psychological functioning accompanying high scores, but not with the Graham et al., 1999, investigation of psychiatric outpatients which did not reveal marked concentration difficulties in high *D4* scorers); (b) trouble initiating tasks, reduced energy, and a lack of confidence; and (c) a feeling of diminished interest and involvement in life (consistent with Wrobel's, 1992, findings of feelings of unresponsiveness and mistrust of one's psychological functioning being associated with high *D4* scores). *D4* and *D2* share five items in common. *D4* also shares four items with the Lack of Ego Mastery, Cognitive subscale (*Sc3*) and five items with the Lack of Ego Mastery, Conative subscales (*Sc4*), both reflecting mental insufficiency (Nichols and Greene, 1995). Graham et al. (1999) reported that for high *D4* scorers both men and women outpatients reported a history of physical abuse, while men reported being sexually abused. Women outpatients were also described as suspicious and as being overly sensitive to criticism. According to Caldwell (1988), low *D4* scorers do not complain that their judgment is impaired or that they are unable to be as cognitively efficient as others.

Brooding (*D5*)

T-Scores > 65 are indicative of individuals who:

1. brood, ruminate, and cry much of the time
2. lack energy to cope with their problems
3. may have concluded that life is no longer worthwhile
4. feel that they are losing control of their thought processes

T-Scores < 40 are indicative of individuals who:

1. feel happy most of the time
2. feel that life is worthwhile
3. deny a lack of energy, brooding, or frequent crying

D5 (Brooding—10 items):

“Ruminativeness; irritability” (Harris and Lingo).

The second of the mood subscales of Scale 2, *D5* is the most heavily saturated with obvious depressive content of the Scale 2 subscales. Eight of its 10 items overlap *DEP* (half of these on *DEPI*), amounting to 8 of the 9 items shared by

Scale 2 and *DEP*. *D5* is highly correlated with Scale 7 (.89), *Hy3* (.81), *Pd5* (.82), *Sc4* (.85), *ANX* (.84), *DEP* (.92; *DEP2* [.91], *DEP1* [.86], *DEP3* [.80], *LSE* [.80]), and *NEGE* (.80). It combines a sense of being easily upset with that of misery and agitation. For interpretative purposes, it is most useful when compared with *D1* rather than the full Scale 2. *D5* is more angry and expunitive than *D1*.

D5: Brooding (10 Items)

D5 and the *DEP* content scale for the MMPI-2 overlap by eight items. Eight of the items are keyed True direction, two False. The *D5* content suggests that one feels not worthwhile, useless, lacking energy and, when elevated in conjunction with a high Scale 2 score, adds to the hopelessness of the depression (Caldwell, 1988). Irritability and a proneness to rumination are likely correlates (Wrobel, 1992). Interestingly, men but not women among the Graham et al. (1999) psychiatric outpatients were described as worriers. However, Levitt (1989) was correct to report that the scale title, “Brooding,” appears derived from a single item (item 215). The other seven items are the most heavily saturated with the obvious depressive content among the Scale 2 subscales. Nichols and Greene (1995) stated that *D5* is a measure of general distress and is sensitive to anhedonia. They also note that *D5* can predict the intensity and pervasiveness of guilt, which is also reflected in the Self-Alienation subscale (*Pd5*). Specifically, guilt will be more clearly identifiable when *D5* and *Pd5* are both elevated above the *OBS* content scale, as well as above the level of other distress scales, such as Anxiety (*A*) and the following content scales: Anxiety (*ANX*), Fears (*FRS*), Depression (*DEP*), Work Interference (*WRK*), and Negative Treatment Indicators (*TRT*). Nichols and Greene (1995) underscored the fact that *D5* is saturated with first-factor variance (i.e. general maladjustment), which places an emphasis on feeling miserable and upset. *D5* is highly correlated with Scale 7 (.89), *Hy3* (.81), *Pd5* (.82), *Sc4* (.85), *ANX* (.84), *DEP* (.92), *LSE* (.80), and *NEGE* (.80). “It combines a sense of being easily upset with that of misery and agitation. For interpretative purposes, it is most useful when compared with *D1* rather than the full Scale 2” (Nichols, 2011, pp. 103–104). All 10 of the *D5* items overlap with *D1* (Subjective Depression), with *D5* expressing more anger and extra-punitiveness than *D1*. Caldwell indicated that a low *D5* score, especially with an accompanying low *T*-score on *D*, may indicate a capacity to respond with resiliency to life’s stresses.

Scale 2: Subtle–Obvious Subscales

D-O (Depression-Obvious—39 items): *D-O* contains 28 of the 32 items of *D1* ($r = .98$) and is nearly identical to the latter.

D-S (Depression-Subtle—18 items): *D-S* is a subtle measure, not of depression as such, but of the inhibition of crude affect. It reflects passivity, subassertiveness, and tolerance for domination/subordination. It overlaps *D2* by seven items and is moderately correlated with *ANG* (–.59), *Re* (.57), *ANG1* (–.57), *Ma4* (–.57), *TPA* (–.56), *TPA2* (–.55), and *ASP* (–.55). It and *AGGR* (low) are probably the best traditional MMPI-2 measures of inhibited aggression (but see *Dr2*, as follows).

About two thirds of the 57 items on Scale 2 have obvious content. The Depression-Obvious subscale (*D-O*) has 39 items, of which 17 are keyed True, 22 False. Depression-Subtle (*D-S*) has 18 items, of which 3 are keyed True, 15 False. The item composition, scoring keys for the S–O subscales, and linear *T*-score conversions for all of the Wiener-Harmon subscales for men and women can be found in Friedman et al. (2001, Appendix A.2, pp. 539–551, and Appendix B.6, pp. 506–608). Caldwell (1988) described the *D-O* items as covering a “broad depressive spectrum” (p. 15), including feeling unhappy, worried, and useless; crying easily; and having sleep and appetite problems. The 18 subtle items include a cluster pertaining to the inhibition of anger, aggression, and self-assertion. Nichols and Greene (1995) reported a similar description, adding that the *D-S* subscale reflects an inhibition or suppression of irritability and sadism in emotional life and fantasy. Later, Nichols (2011) was even more specific in stating that *D-S* is a subtle measure, not of depression, as such, but of the inhibition of crude affect. *D-S* reflects passivity, subassertiveness, and tolerance for dominance/subordination. *D-S* and Aggressiveness (*AGGR*) (low) are likely the most useful measures of inhibited aggression. *D-S* overlaps *D2* by seven items and is moderately correlated with *ANG* (–.59), *Re* (.57), *ANG1* (–.57), *Ma4* (–.57), *TPA* (–.56), *TPA2* (–.55), and *ASP* (–.55).

Other subtle items report lacking perseverance and “never feeling euphoria or even unusually good” (Caldwell, 1988, p. 15). W. G. Dahlstrom (personal communication, 1997) suggested that the subtle items may reflect a predisposition to develop the disorder that the parent scale is measuring. For example, an individual scoring low on *D-O* but high *D-S* may have a tendency to develop depression. In general, individuals with greater levels of maladjustment tend to endorse more obvious items, whereas defensive responders or persons with milder forms of psychopathology tend to endorse primarily subtle items in describing their feelings (Dahlstrom et al., 1972). Hollrah et al.’s (1995) review of the S–O convergent validity literature led them to caution that *D-S* is not a valid measure of depression. They stated, however, that the decision to use only *D-O* should be evaluated with caution. They found *D-O* to be better than the full *D* scale when measuring obvious depression symptoms. They also reviewed studies that show support for both the full *D* scale and the discriminant validity of the *D-S* subscale.

Dahlstrom (1991) reported several correlates for men and women for each of the S–O subscales derived from partner ratings in the re-standardization sample. For *D-O*, trouble sleeping, unrealistic attitude about abilities,

worries about health, a lack of energy, multiple fears, a tendency to get sad, a lack of confidence, and complaints of body aches all characterized male and female participants. For women scoring high, the following descriptors were generated: nervous, not cheerful, not pleasant or relaxed, cries easily, concerned about death, and avoiding contact with others. *D-S* subscale elevations were associated with the following descriptors for both men and women: does not swear or curse, dislikes flirting, cooperative, thoughtful of others, pleasant and relaxed, and attends religious functions. Specific to women only, the following descriptions were given: self-confident, few fears and bad dreams, does not break things when angry, not lacking in emotional control, not stubborn, does not worry about the future, and gets along well with others. Men were described as: not moody or bossy, friendly, does not take prescription drugs, not argumentative or critical of others, and does not get angry and yell.

Caldwell (1988) reported that low *D-O* scores reflect an individual who has ample self-confidence and feels that life is worthwhile, whereas low *D-S* scores reflect willfulness and assertion, and the capacity to feel anger as it is situationally appropriate.

The MMPI and Suicide

It has often been reported as important to consider suicide risk when Scale 2 is prominently elevated. However, Greene (2011) reported that less than 8 percent of the clients in a large clinical sample with spike 2 codetypes actually endorsed items directly inquiring about suicidal ideation and attempts. This is less frequent than most other codetypes. Nevertheless, items 150, 303, 506, 520, 524, and 530 should be routinely reviewed regardless of the Scale 2 elevation, as these items all pertain to suicide (Glassmire, Stolberg, Greene, & Bongar 2001, Suicidal Potential Scale). Nichols (2010) developed the Hopelessness Scale (*Hp*) regarding suicide risk, as hopelessness is a strong predictor of suicidal ideation, intent, and completed suicide. His 12-item *Hp* scale was derived by inspecting item-total correlations for each of the six suicide items listed above. The reader is advised to contact Nichols for a copy of this potentially useful scale and its psychometric properties. Koss and Butcher (1973) and Koss, Butcher and Hoffmann (1976) also identified suicide items by examining the MMPI responses from 723 male Veterans Administration clients in crisis situations, including those experiencing depressed-suicidal ideation. Of their 78 critical items, 22 pertain to depressed-suicidal ideation with this item set augmented by some of the new MMPI-2 items. Four items, 303, 506, 520, and 524, indicate a self-report of past or present suicidal ideation or behavior. Because depression as measured by Scale 2 and suicide are linked, and given the extent of public concern about the high suicide rate in the the USA with suicides occurring at two to three times the rate of homicides (Friedman, 2008), it is important to briefly discuss the prediction of suicide from the MMPI-2. A fuller discussion regarding multiple MMPI-2 indices

and prediction factors can be found in a review of suicide and the MMPI inventories by Friedman, Archer, and Handel (2005) from which much of the following discussion is derived.

Decades of research have shown that the MMPI cannot predict suicide, but several authors have argued that the prediction of suicide potential, rather than the prediction of actual completed suicide, remains an important assessment challenge. Clopton (1979) succinctly stated that the "...research question of most clinical relevance is whether MMPI data are of assistance in the identification of individuals who will later attempt suicide, not whether MMPI data are sufficient for such identification" (p. 162). This statement is consistent with the current literature on the prediction of dangerousness, which is based in great part on psychiatric and forensic subjects. The current thinking about risk has taught us to move away from trying to predict specific acts of dangerousness or violence in an open-ended time frame. We have come to think in terms of evaluating the probability of an individual perpetrating an act of violence in a briefer and defined window of time, dependent on the knowledge that many factors, which can shift or change rapidly, influence the propensity for violence. The move to a risk assessment model from dangerousness prediction, per se, can also be applied to MMPI-2 interpretation. As Friedman et al. (2005, p. 65) state: Numerous factors influence an individual to think and behave in a suicidal (or homicidal) manner, including, but not limited to, changes in personal circumstances, such as loss of support from significant others, irreversible business losses, or the worsening of a medical condition with intractable pain. The exacerbation of severe psychiatric symptoms may also increase suicide risk, such as command hallucinations, intolerable depressive symptoms, or alcohol and/or drug intoxication. The value of the MMPI lies in being part of a risk assessment mosaic that includes interview data, collateral sources of information, and other psychometric data to help serve the mission of estimating suicide potential rather than the prediction of actual suicide. In this fashion, the test data can help inform and guide a risk management strategy.

The prediction of suicide is too complex a phenomenon to be measured reliably by any single variable or even a combination of indicators on the MMPI-2 or any other psychometric instrument. The low base rate problem is a critical factor to consider, but other ingredients come into play, such as an individual's motivation to report accurately their feelings and their own self-awareness of their intentions. In some cases, attempts or gestures are impulsive acts, perhaps unleashed by the disinhibiting effects of a substance such as alcohol, cocaine, or a barbiturate. The prevention of suicide or suicide attempts, commonly associated with mental illness, falls well within the province of the responsibilities of mental health practitioners. Psychologists and psychiatrists are looked on by the public and courts to make difficult decisions about the risk status of individuals, frequently as a core element in involuntary hospitalization decisions. The MMPI-2 is used clinically and forensically, and it is not uncommon for a hospital and the clinicians involved in treatment of a suicidal patient to be sued for malpractice, often resulting from

incidents in which a patient, either discharged or given a leave or pass, subsequently committed suicide. As Friedman et al. (2005, p. 66) noted: The MMPI and other test data are usually obtained and examined following these incidents for signs or markers that could have alerted the clinicians and diagnosticians that the patient was a high-risk or at-risk candidate for attempting or completing suicide. These so-called “psychological autopsies” force clinicians to re-examine their decision-making process, and they often rely on the research literature to justify their judgments.

Nichols (1988) concluded that the many research investigations conducted during the 30 years preceding his review produced few valid correlates of, and nothing of substantive clinical value, for predicting suicide with the MMPI. If researchers are to be more productive in this area, Nichols recommended collaborative efforts to build up adequate-size samples of individuals who had completed suicide within a short time frame (e.g. one week) after having completed the MMPI. He opined that since suicide may more closely approximate the final common pathway of a concatenation of demographic, situational, and personologic variables than a unitary trait disposition, the constitution of suicidal and appropriate comparison groups may require the institution of more extensive and sophisticated inclusion criteria and controls than those found tolerable in previous studies. (Nichols, 1988, p. 103)

Unfortunately, few studies have been able to approach the degree of sophistication recommended by Nichols, and he pessimistically concluded that even if such work was to be done, “the clinical payoff for even valid and reliable MMPI correlates of suicide, assuming that such might eventually be found, is most unlikely to compensate the research efforts necessary to develop them” (p. 104). However, such test correlates, even if unable to accurately predict suicide, would nevertheless add to our understanding of suicidal behavior.

Suicide studies with the MMPI-2 vary along a number of dimensions. These investigations have examined MMPI/MMPI-2 data in terms of items, scales, and profile configurations or code patterns, with the subjects of these studies varying from suicide ideators, threateners, gesturers, and attempters, to successful suicides. Other important participant factors include the age, gender, and personal characteristics of the person, such as his or her voluntary versus involuntary hospitalization status (Leonard, 1977).

The available literature from the MMPI, MMPI-2, and MMPI-A provides little evidence that items, scales, or profile configurations are of practical use in the critical determination involving an adolescent’s or adult’s probability of engaging in suicidal behavior. Although substantial research has shown that the various forms of the MMPI are not directly useful in the prediction of suicide, numerous researchers and authors have argued that the instrument is useful in prediction to more common aspects related to suicidal phenomena, particularly the occurrence of suicidal ideation. The degree to which the endorsement of suicidal ideation on the MMPI-2/RF (or MMPI-A) is likely related to the occurrence of actual suicidal behaviors is probably mediated by numerous factors, including the individual’s

history or prior suicidal behaviors, family history, access to lethal methods, and the presence or absence of a variety of personality features and/or psychiatric symptoms including depression, impulsivity, alienation, and the occurrence of anger or rage. Suicidal ideation is relatively common among numerous psychiatric groups and even among adolescents in the MMPI-A normative sample. While the MMPI-2/RF (and MMPI-A) may not be able to accurately predict the occurrence of suicidal behavior, these tests have potential usefulness in uncovering the presence of suicidal ideation in adolescents and adults, and can be of significant value in performing an overall assessment of suicide risk or potential. The MMPI-2/RF should always be combined with multiple sources of other data including clinical interview, comprehensive psychosocial history taking, and results from a variety of other psychometric instruments in any evaluation of suicide issues.

03 – Hy – *Hysteria*

Scale 3 (Hy)



Summary Descriptive Features of Hy

Number of Items: 60

True/False Balance: 13/47

Overlap: 20 items with Scale 1, 15 with *HEA* and *RC1*, 13 with Scale 2, and 10 with *K*.

Content: Somatic complaints; health dysphoria, anxious depression, social interest/initiative, and denial of cynicism and mistrust.

Relations with Other Scales: The relations between Scale 3 and other scales are misleading when based on correlations obtained within psychiatric samples, because symptoms and complaints within such samples will be overweighted relative to those aspects of the scale that reflect social interest and comfort, a trusting and positive self-portrayal, and a distaste for aggression and conflict. Correlations between the obvious (*Hy-O*) and subtle (*Hy-S*) components of Scale 3 and other scales will be discussed along with those scales.

Among the basic clinical scales, Scale 3 is most highly correlated with Scales 1, with which it shares 20 (mostly somatic) items at .80, and 2, with which it shares 13 items at .72. It is correlated with *HEA* at .70. Its configural relation to Scale 1 has a variety of implications: 1 greater than 3 suggests more somatic complaints, greater pessimism and defeatist attitudes, and greater extractiveness and abrasiveness in relations with others; when 3 is greater than 1, the Scale 1 trends are moved in the direction of fewer somatic complaints, more optimism and poignancy, more social skill, and a more appealing if not seductive approach to others. Content scale correlates of Scale 3 are highly disparate between normal and abnormal samples. The high (*HEA*) and moderate (*ANX*, *DEP*, *WRK*) correlations seen in psychiatric samples collapse or reverse in normal samples, whereas the negative moderate (*ANG*, *CYN*, *ASP*, *TPA*) content correlates within normal samples collapse or reverse in psychiatric samples. Elevations on *L* and *K*, especially when combined with low scores on Scales *F*, 7, 8, and 0, emphasize the success of defensive operations in warding off anxiety.

1) 60 items some of which reflect **physical complaints and troubling disorders**
and others which reflect denial of problems and a lack of social anxiety

a. *Examples: 44. Once a week or oftener I suddenly feel hot all over, for no reason. (T)*
176. I have very few headaches. (F)

2) scale constructed on patients who exhibited some form of sensory or organic motor disorder for which no organic basis could be established.

4) **T-Scores > 65 (marked elevation) are indicative of individuals who:**

- a. react to stress and avoid responsibility through the development of physical symptoms
- b. may report headaches, stomach discomfort, chest pains, weakness, and tachycardia
- c. have symptoms that may appear and disappear suddenly
- d. do not report severe emotional turmoil
- e. rarely report hallucinations, delusions, or suspiciousness
- f. lack insight concerning causes of symptoms
- g. lack insight about their own motives and feelings
- h. are psychologically immature, childish, and infantile
- i. if psychiatric patients, receive diagnoses of conversion disorder or psychogenic pain disorder
- j. are self-centered, narcissistic, and egocentric
- k. expect a great deal of attention and affection from others
- l. use indirect and devious means to get attention and affection
- m. do not express resentment and hostility openly
- n. tend to be emotionally involved, friendly, talkative, and alert
- o. have superficial and immature interpersonal relationships
- p. are interested in what other people can do for them
- q. occasionally act out in a sexual or aggressive manner with little apparent insight into their actions
- r. initially are enthusiastic about treatment
- s. view themselves as having medical problems and want medical treatment
- t. are resistant to psychological interpretations
- u. are likely to terminate treatment if their therapists insist on examining psychological causes of symptoms
- v. may be willing to talk about psychological problems as long as they are not conceptualized as causing their symptoms
- w. often respond well to direct advice and suggestion

- x. when involved in therapy, often discuss worry about failure at work and school, marital unhappiness, lack of acceptance, and problems with authority figures
- y. have histories of rejecting fathers

5) **T-Scores 58-64 (moderate elevation) are indicative of individuals who:**

- a. are likely to be exhibitionistic, extroverted, and superficial
- b. are naive, self-centered, and deny any problems
- c. they prefer to look on the optimistic side of life and avoid any unpleasant issues

6) Normal range: **T-Scores 40-57**

7) **T-Scores < 40 (low scores) are indicative of individuals who:**

- a. do not worry excessively about their health
- b. do not present somatic symptoms
- c. are constricted, conventional, and conforming
- d. are described as unadventurous, lacking industrialness, and having a narrow range of interests
- e. are cold and aloof
- f. may display blunted affects
- g. have limited social interests and participation
- h. avoid leadership responsibilities
- i. are seen as unfriendly, tough-minded, and hard to get to know
- j. are suspicious and have difficulties trusting others
- k. are realistic, logical, and level-headed in approach to problems
- l. are not likely to make impulsive decisions
- m. seem to be content with dull, uneventful life-styles

T >75 Extreme somatic complaints; consider conversion disorder; reacts to stress by developing somatic symptoms which may disappear when stress subsides; chronic pain

T = 65---74 Somatic symptoms; chronic pain; lacks insight concerning causes of symptoms

T = 55---64 Somatic complaints; denial, immature, self---centered; demanding; suggestible, affiliative

T = 45---54 Average score; no interpretation

T <45 Low score; no interpretation

>80 - might be conversion reaction denial of psychological and interpersonal problems and vulnerabilities and specific somatic problems, psychologically naive, narcissistic, neurotic defenses, need attention, suggestible, may have problems with authority, sexual & aggressive acting out or be overly conventional moderate elevation – pollyannish

very low - tough-minded, cynical, misanthropic or low need for people, narrow range of interests, conforming, show little affect

One defense against intolerable emotionally painful conditions is to deny that they exist. Another approach is to switch the focus of attention away from something painful onto something positive, even in the face of overwhelming pain. Scale 3 measures the intensity and need for such denial and positivization. As Scale 3 is elevated over a *T*-score of 70, denial, remaining positive in the face of pain, and seeking approval from others become a core element of the individual's personality. In some situations, however, elevations on Scale 3 may reflect an individual's current level of stress, perhaps defending against an underlying depression. Scale 3 attributes are generally neurotic and so predict against psychosis, particularly when Scale 3 is one of the two most elevated scales in the profile. High scores ($T > 65$) suggest that an individual is using repression and denial as a primary defense mechanism. These individuals are usually conforming, somewhat naive, and can appear immature and self-centered. They also exhibit somatic preoccupations and concerns about physical illness, but generally with an absence of congruent affect. High Scale 3 individuals can appear demanding of attention, affection, approval, and support from others, but they also can be very emotionally giving to others. This reflects their needs to be nurtured and supported. They tend to be active socially and fear abandonment. Consequently, intimacy with others, while highly appealing, is also frightening to them. Because repression and denial are primary defenses, they tend to lack insight into the dynamics that drive their behavior. Some individuals with high Scale 3 scores may be described as dramatic or exhibitionistic, perhaps reflecting the intensity of their emotional experience. Aggressive acting out is unlikely if Scale 3 is the only scale elevated above *T*-65. Elevations on Scale 3 can be viewed as reflecting an individual's fear of emotional pain. Shifting the focus onto positive events and denying anger and resentment will minimize the possibility of displeasing others and eliciting their rejection or disapproval. Because of strong needs to be liked, high Scale 3 scorers can respond enthusiastically to situations requiring their commitment. However, their difficulty in dealing with conflict

and their inability to recognize and express their own resentments and anger can lead to their feeling hurt and unappreciated. Uncomfortable with anger, they tend to express it in passive ways. Lacking self-awareness, they vent their anger through humor and through somatic problems. In other words, their physical symptoms act as a symbolic expression of their underlying conflicts.

A moderately high score (T -55–65) on Scale 3 can reflect an individual who is optimistic and positive and could be described by others as agreeable. These individuals are people pleasers who are uncomfortable with conflict. They can develop mild physical symptoms in response to stress, which diminish once the stress has passed. Individuals with a T -score less than 45 can be seen by others as somewhat cynical, although they probably see themselves as grounded and realistic. They may be seen by others as somewhat blunt and even caustic. In a flat profile with an absence of any scale elevation above a T -60, a low Scale 3 reflects individuals who see themselves as practical, sensible, and willing to “call a spade a spade.” They lack tact, tend not to be complimentary of others, and typically express emotions without embellishment or color. When other scales are significantly elevated, a low Scale 3 score would suggest a painful awareness of emotional distress, with a lack of the potentially positive consequences of repression and denial.

The diagnosis of hysteria, although common in the 1930s, was difficult to establish because clear-cut criteria in the clinical concept were lacking, hysterical phenomena were concurrent with other neurotic symptoms in the same individual, and there was diagnostic uncertainty of hysterical reactions in individuals who were suspected of having organic disease (McKinley & Hathaway, 1944). Thus, the 60-item *Hys* scale was originally developed to aid in the diagnosis of hysteria and to measure the degree to which a patient is likely to develop symptoms of conversion. Conversion symptoms included “fits” (e.g. fainting, blackouts, and pseudoseizures), abdominal pain, and stress vomiting; amnesia, fugue, and somnambulism; paralysis; contractures (e.g. writer’s cramp); tremors; speech irregularities (e.g. aphonia/mutism, stammer, stutter, lisp, whispering, or other mannerisms/affectations); spasmodic movements; awkward or impaired gait; episodic weakness and fatigue; anesthesia, deafness, blindness, and blurred or tunnel vision; and cardiac crises (e.g. palpitations). “In fact, the range and variety of conversion symptoms are endless; hysteria has been called ‘the great imitator’ for its ability to simulate the signs and symptoms of organic illness” (Nichols, 2011, p. 113). The symptoms can be difficult to understand in isolation, but become less ambiguous:

- a) when they are observed to be recurrent but transitory and reversible;

- b) when they are judged to be related to some significant emotional stress that preceded symptom onset, or to serve some communicative function (e.g. emotional appeal) or to have iconic significance;
 - c) when the symptom appears in some way to resolve or comment on a conflict deemed to follow or be otherwise related to the precipitating stressor;
 - d) when the medical diagnostic pursuit of symptoms has non-confirmatory outcomes.
- (Nichols, 2011, p. 113)

It should be noted that the symptom(s) may be of either recent or distant onset with the former manifesting suddenly in response to stresses that have profound emotional significance or that remind the patient of some previous emotionally traumatic event. In cases of distant onset, the precipitating event is obscure or unknown, and the emotion surrounding it blunted. Symptoms are typically more numerous, less dramatic, and apparently disabling, and seem intended to confirm or legitimize the patient in a sick role. (Nichols, 2011, p. 116)

La belle indifference is typically absent, and the patient may exist as an invalid, freed of all responsibilities apart from seeking treatment. Secondary depression is often manifested, shading into the symptom pictures typical of hypochondriacal or somatization disorders. The re-standardization left the composition of *Hy* intact, with no item deletions, although nine items were modified to modernize idioms and usage, grammatical clarifications, and simplifications.

The participants in the criterion group were taken primarily from the inpatient service of the psychiatric unit at the University of Minnesota Hospitals. McKinley and Hathaway (1944, as cited in Dahlstrom & Dahlstrom, 1980, p. 46), described the criterion participants as follows:

They had each received the diagnosis psychoneurosis, hysteria, or had been especially noted as having characteristic hysterical components in the personality disturbance. In the assignment of these diagnostic terms, the neuropsychiatric staff followed, as closely as possible, current clinical practice. Where cases showed a simple conversion symptom such as aphonia, an occupational cramp, or a neurologically irrational anesthetic area, the diagnosis was usually well agreed upon. In some cases, there remained a doubt as to whether there was a true organic illness such as multiple sclerosis present or whether the syndrome reflected hypochondriasis or an early schizophrenic reaction.

Participants with less dramatic symptomatology made psychodiagnosis a more difficult and less certain task. After several attempts, a final criterion group consisting of 50 cases was selected. Although no modal description or

demographic data for the *Hy* criterion hysteric patients were provided (Colligan et al., 1983), the patients included in the criterion group did manifest the “neurotic defenses of the conversion form of hysteria” (Dahlstrom et al., 1972, p. 191) or hysterical personality features. In individuals who had developed an involuntary psychogenic loss or disorder of function, the physical symptoms allowed them to evade responsibilities and to escape from stressful and unpleasant situations. It was thought that patients whose personality organization revolves around hysterical defenses tend to function adequately or even well under ordinary circumstances, but when faced with difficult situations the tenuous nature of their personality organization is taxed beyond its capacity to cope, and symptoms emerge reflecting an overburdened self (e.g. emotional lability, emotional intensity, and modulation difficulties). Dahlstrom, et al. noted that a need to detect such a predisposition for breakdown was necessary and was in part the motivation for the development of Scale 3. It was immediately apparent to McKinley and Hathaway that *Hy* included two major categories of items. One referred to somatic complaints; the other to an extraverted social style.

The bodily complaint items related to such symptoms as headaches, dizzy spells, and hand tremor. As McKinley and Hathaway (1944) pointed out, the declaration of social well-being was illustrated by the frequent endorsement of denying items declaring bashfulness, getting angry easily, and opposing bossing others, even if the demands were justified. Despite the predominance of these two types of items, several other items referred to feelings of dysphoria (“blue” or “unhappy”). Specifically, item 65 admits feeling down most of the time, whereas item 95, denies feeling generally happy. The subsets of items describing somatic complaints, and feelings of well-being and comfort, are usually independent of each other or negatively correlated in normals, but tend to be positively correlated in patients whose personality functioning is organized around hysteric psychodynamics. Generally, the more elevated and prominent the role of Scale 3 in a codetype, the less insightful the individual tends to be, and the more likely it is that physical symptoms will emerge when the individual experiences stress.

Greene (1991a, 2011) reviewed the relation of Scale 3 item content to other scales and underscored the correspondence of its content to the independent clusters of items reported by Little and Fisher (1958). The two clusters, *admission of physiologic symptoms* and *denial of symptoms*, were used to construct the Admission (*Ad*) and Denial (*Dn*) scales. Greene (2011, p. 116) stated that:

The *Ad* scale correlates positively (.96) with Scale 1 (Hypochondriasis [*Hs*]), the two scales having 18 items in common. The *Dn* correlates positively (.84) with Correction (*K*), with which it shares 9 items. Clients who score high on *Ad* report a number of nonspecific somatic symptoms and have poor interpersonal relationships. High scorers on *Dn* are described as lacking insight into their own behavior and morally

virtuous. Little and Fischer (1958) believed that when both *Ad* and *Dn* scales are elevated, the person should have conversion-reaction dynamics.

Note that the *Ad* and *Dn* scales virtually overlap the obvious and subtle components of Scale 3, respectively.

The normal group used in the construction of *Hy* consisted of 200 women and 139 men, all married and between the ages of 26 and 43, who typically had eight years of schooling, with few educated beyond high school. The second group of normals consisted of 114 women and 151 men who were entering college and included to control for age and intelligence (McKinley & Hathaway, 1944). McKinley and Hathaway viewed *Hy* as measuring a variable trait closely related to the construct measured by Scale 1 (*Hs*). There is considerable overlap between Scales 1 and 3, 20 items, the most item overlap shared by any two clinical scales. The positive correlation between Scales 1 and 3 motivated McKinley and Hathaway to attempt to decrease this correlation by eliminating as many of the overlapping somatic items as possible. The results of this effort are best summarized by McKinley and Hathaway (1944, as cited in Dahlstrom & Dahlstrom, 1980, p. 47):

Elimination of the somatic items resulted in a marked drop in the number of test cases identified and introduced another disturbing difficulty; if only the nonsomatic items were used, there was a strong relation with age and education. The mean score was more than a half sigma higher for the college group than for older persons. These results forced the inclusion of some somatic items in the final scale with consequent high correlation ($r = .52$ normals and $r = .71$ clinic cases) between *Hs* (hypochondriasis) and *Hy* (hysteria). Some relation still remains between age and intelligence and the *Hy* score. The relation seems valid clinically. It appears that the positive correlation between Scales 1 and 3 is not a simple artifact of the item overlap but reflects a common psychological dimension in the elevation of these two scales, apparently somatization (Friedman et al., 1983; Marks & Seeman, 1963). It is important to note that McKinley and Hathaway distinguished clinical differences between individuals when both scales were elevated but with one score higher than the other. Specifically, they identified a different prognosis and treatment for these patterns of scores (McKinley & Hathaway, 1944, as cited in Dahlstrom & Dahlstrom, 1980, p. 49):

Where *Hs* was higher, the physical complaints were diffuse and frequently required much less study to establish the presence of an important psychological factor in the disability. On the other hand, when *Hy* was dominant, the person frequently appeared normal psychologically and his physical complaints were likely to mimic closely or be accompanied by some common physical syndrome of the type now called "psychosomatic." As previously stated, Scale 3 is highly correlated with Scale 1 ($.80$) due to the overlap of somatic items and it also shares 13 items with Scale 2 ($r = .72$). It is also correlated with *HEA* at $.70$. Its configural relation to Scale 1 has a variety of implications: Scale 1 elevated greater than Scale 3 suggests more somatic complaints, greater pessimism

and defeatist attitudes, and harshness in relations with others; when Scale 3 is elevated above Scale 1, the latter tends to reflect fewer somatic preoccupations, greater optimism and social adeptness, and even a seductive approach toward others.

Nichols (2011) emphasizes that the use of the ego defense mechanism of denial can be quite striking in those with prominent scale elevations. Problems and difficulties that others easily recognize as emotional or psychological in nature in the client are typically denied as having any validity.

For example, the patient may deny frank and disabling illness, documents bearing his or her signature, well-documented events in his or her history, a large dress size, pregnancy, a spouse's alcoholism or imprisonment, or divorce, even in the face of clear, graphic, and incontrovertible evidence. The patient appears simply to bypass such evidence, to glide over it in a way that prevents effective confrontation. The manner of denial generally is not to argue that the evidence is unproven, but rather is flat, unequivocal, and final. Repression (keeping painful feelings and images out of awareness) appears to be the central defensive operation in Scale 3. (Nichols, 2011, p. 119)

Duckworth and Anderson (1995) also pointed out that denial and repression are the primary mechanisms of defense being tapped by Scale 3. Therefore, although symptoms associated with other scale scores greater than that for Scale 3 may be acknowledged by the individual, those indicated by scales with *T*-scores below that for Scale 3 may not be acknowledged and the person may show a distinct absence of insight. Greene (2011) suggested that this rule should be used cautiously, given the lack of research to support it. Note that elevations on Scales *L* and *K*, especially when combined with low scores on Scales *F*, 7, 8, and 0, emphasize the success of defensive operations in warding off anxiety.

The scoring direction for the majority of the items on Scale 3 is False. Forty-seven (78 percent) of the items are keyed False, with 13 (22 percent) keyed True. As with Scales 1 and 2, a tendency to endorse items False will also elevate Scale 3 (see Chapter 4 for a description of an All-False response set profile). Scale 3 has fairly evenly distributed overlap with the other clinical scales and also shares 15 items with *HEA* and *RCI*, and 13 with Scale 2. Although no *K* correction is added to Scale 3, there is, in effect, a builtin *K* correction factor since Scale 3 has 10 items in common with *K*. Caution is urged when examining the correlations between Scale 3 and other scales, specifically when comparing psychiatric patients to normal samples. Symptoms within such samples tend to be overweighted relative to those aspects of the scale that reflect social interest and comfort, a trusting and positive self-portrayal, and a distaste for aggression and conflict. As Nichols (2011) points out, the high (*HEA*) and moderate (*ANX*, *DEP*, *WRK*)

correlations seen in psychiatric samples collapse or reverse in normal samples, whereas the negative moderate (*ANG, CYN, ASP, TPA*) content correlates within normal samples collapse or reverse in psychiatric samples.

The item content in the scale is varied, covering areas of appetite, good sleep hygiene, somatic complaints, dysphoria, anxious depression, social interest/initiative, and denial of cynicism and mistrust. High scores on Scale 3 are obtained by individuals often described as childish self-centered with strong needs for approval and affection. They will seek reassurance that they are likable and will try to elicit it by flattering, rewarding, and complimenting others (Lewak et al., 1990; Levak et al., 2011). They tend to be cheerful, animated, and talkative, if not vivacious and flamboyant, and approving if not seductive. They are strongly oriented to present themselves as socially attractive as possible. Nichols (2011, p. 116) states that:

...there is a tendency for their expression to be exhibitionistic and toward dramatization in social situations as well as at the level of symptom(s) and mood ... suggestibility is also common, with the high scale 3 scorer being subject to influence, imitativeness, marked shifts in feeling and mood, and to the rapid embrace or abandonment of attitudes and convictions, often seemingly dependent on the person with whom the patient last spoke. (Nichols, 2011, p. 116)

In describing the “Hysterical Style,” Shapiro (1965) offers further insight into the way these individuals perceive and process information. He suggests that hysterical cognition, in general, is “relatively diffuse, and lacking in sharpness, particularly in sharp detail. In a word, it is *impressionistic*” (Shapiro, 1965, p. 111). For example, a person with distinct hysteric traits is likely to respond to questions asking for facts with not a factual answer, but rather impressions. “These impressions may be interesting and communicative, and they are very often vivid, but they remain impressions, not detailed, not quite sharply defined, and certainly not technical” (Shapiro, 1965, p. 111). The individual, nevertheless, believes that their judgment is sound and thinking is unfettered, clear, and rational, but with a feeling that his or her mental functioning should never be put to the test. Their inability to be accurate or engage in critical thinking inclines them to embellish or fabricate events or experiences, sacrificing truth and accuracy in the hope of greater impact or appeal upon others. They are often viewed as looking but not seeing; listening not hearing, as if their information processing is hampered by sensory inhibition. (Nichols, 2011, p. 117)

The way in which a patient presents with a significant *Hy* elevation is quite varied depending on the way in which two fairly distinct groups of items are endorsed. The somatic complaints, many with dysphoric overtones, and a second set of items, affirming freedom from emotional difficulties and a sociable orientation toward others, often differentiate and characterize differently the presentation of the patient. When the somatic items dominate in the total *Hy* score, the patient is “likely to manifest a clear somatic focus and experience significant discomfort and distress in the form of depression, anxiety, or nervousness” (Nichols, 2011, p. 114). When the somatic items are

exceeded by the items emphasizing sociability, optimism, and denial of social anxiety, there is denial about somatic concerns but also a proneness to worry and inhibitions around aggression and anger. La belle indifference is the lack of worry or indifference to one's somatic symptoms and related disability, despite normal concern about other matters, and is often apparent in patients strongly endorsing the *Hy* items emphasizing well-being. Regardless of which items are endorsed, a prominent Scale 3 elevation reflects self-centeredness, but tends to be expressed demandingly when the somatic items are more frequently endorsed than the items asserting freedom from emotional difficulties, wherein the self-centeredness is expressed more appealingly or seductively. Conformity and naivete are characteristic, along with the absence of insight due to the predominance of denial and repression in personality organization. Fearful of emotional and physical pain, high Scale 3 scorers tend to limit their awareness, which

can result in impaired reality testing under stressful circumstances (Caldwell, 1974).

Levak et al. (2011) suggested that it is helpful to look for what these individuals explicitly deny because that is often at the center of their conflict. Sociable, but shallow in their relationships, high Scale 3 scorers can become resentful of perceived demands and develop somatic concerns to remove themselves from responsibilities they resent or fear being unable to handle. It is rare for high scorers to develop psychotic symptoms, although their symptom pictures can be quite pronounced when they feel overwhelmed. Although the behaviors measured by Scale 3 are trait-like in appearance, the item content reflects behaviors that can change over time. The phrasing of the items in the present tense also allows test takers to interpret the items according to their current circumstances. For these reasons, Dahlstrom et al. (1972) stated that the scale may show less test-retest agreement relative to other scales, and that split-half estimates of reliability are inappropriate or misleading for Scale 3.

The *Hy* test-retest correlations for psychiatric patients ranged between .66 and .80 for intervals between one and two weeks, and between .36 and .72 for a one-year interval between tests (Dahlstrom et al., 1975). Butcher et al. (2001) provided test-retest reliability coefficients for 82 normal men and 111 normal women retested at an average interval of about one week, with the men and women obtaining coefficients of .70 and .74, respectively. Hunsley et al.'s (1988) large-scale meta-analysis of reliability studies using a wide variety of populations conducted between 1970 and 1981 reported an average internal consistency of .78 across 70 studies, and also reported an average test-retest reliability of .74 for 15 studies with time intervals from one day to 2 years. In contrast to the Hunsley et al. internal consistency findings, Butcher et al. (2001) reported much lower estimates of internal consistency; specifically, they reported coefficient alphas of .58 and .56 for men and women, respectively, for the re-standardization sample. The much lower values reported by Butcher et al. is most likely due to the greater diversity in participants used in the Hunsley et al. meta-analysis, which included college students, psychiatric patients, medical patients, alcohol and/or

drug abusers, and incarcerated criminals. Although various correlates for Scale 3 are reported in the literature, it is important that the clinician be selective in choosing the descriptors to be applied to any one individual. Some correlates, for example, although reported to be valid, may not have the validity always ascribed to them. Hedlund (1977), in comparing the results of seven independent studies that attempted to empirically identify the behavioral or symptom correlates of individual MMPI clinical scales for psychiatric patients, found that Scale 3 did not always correlate with specific items of dissociation, amnesia, or conversion symptoms, items that might be assumed to be relevant to the hysteria construct. He did find, however, that Scale 3 was regularly related to a number of somatic complaints (e.g. diarrhea, loss of appetite, and sleep disturbance), and significantly correlated with a number of depression-related complaints. It is recommended that the clinician assess individuals on a case-by-case basis that includes an understanding of their psychosocial history and the context in which they are being evaluated, as well as carefully inspecting the various subscales and supplementary scales to better understand the meaning of the particular clinical scale elevation.

In our opinion, there is no implication that symptoms will be present at elevated scores unless these are at a sufficiently high level (e.g. $T \geq 75$) to have forced the endorsement of some of the somatic items. Conversely, false-negative predictions can easily occur when conversions are singularly localized, and uncomplicated, even when active and manifest. Also, note that elevations on Scale 3 do not rule out medical illness. Organic pathology has been found in high rates of follow-up studies of patients diagnosed with conversion disorder (Halligan, Bass, & Marshall, 2001; Merskey, 1995).

Harris---Lingoes

Hy1 - Denial of social anxiety - extroverted, good social skills, accept criticism

Hy2 - Need for affection - attention-seeking, trusting, nonconfrontational, deny unpleasant facts and feelings

Hy3 - Lassitude-malaise - weakness, fatigue, attention/concentration problems, seek attention

Hy4 - Somatic complaints - specific (chest pain, nausea, etc.)

Hy5 - Inhibition of aggression - deny hostility

Harris-Lingoes Subscales

Harris and Lingoes (1955, 1968) developed the following five subscales for *Hy*: Denial of Social Anxiety (*Hy1*), Need for Affection (*Hy2*), Lassitude-Malaise (*Hy3*), Somatic Complaints (*Hy4*), and Inhibition of Aggression (*Hy5*); they are entirely nonoverlapping, and identical for the MMPI and MMPI-2. No items were deleted for the re-

standardization, so the composition of these subscales has remained intact. It should be noted that the subscales for *Hy* are entirely non-overlapping.

Denial of Social Anxiety (Hy1)

T-Scores > 65 are indicative of individuals who:

1. are socially extroverted
2. feel comfortable interacting with others and feel comfortable talking with other people
3. are not easily influenced by social standards and customs

T-Scores < 40 are indicative of individuals who:

1. are socially introverted
2. are shy and bashful in social situations
3. find it difficult to talk with others
4. are greatly influenced by social standards and customs

Hy1 (Denial of Social Anxiety—6 items): “Extroversion” (Harris and Lingo). *Hy1* is the extroversive component of Scale 3 and the shortest of its subscales. Five of its six items are contained within *Si1* ($r = -.88$) and three within *SOD2*, in both cases keyed oppositely. Four of its items overlap *Pd3* ($r = .90$) and two overlap with *Ma3*. Because of its limited length, it is a less reliable measure of extroversion than Scales 0 and *SOD*. *Hy1* correlates negatively with *A* at $-.65$, suggesting unusual freedom from social anxiety and fear of embarrassment; these items convey the social butterfly aspects of the histrionic personality construct and emphasize social disinhibition. It is one of the *K*-correlated subscales ($r = .61$).

This is the shortest of the *Hy* subscales with six items keyed False. All are contained in Little and Fischer’s (1958) *Dn* and in *Hy-S*. *Hy1* reflects the denial of social shyness and inhibition (social butterfly aspect of the histrionic personality emphasizing social disinhibition) and is never elevated when Scale 0 (*Si*) is elevated. Because of its limited length, it is a less reliable measure of extroversion than Scales 0 and *SOD*. Caldwell (1988) described high scorers as manifesting an “over-socialized friendliness” (p. 19) toward unfamiliar others. Nichols and Greene (1995) described high *Hy1* individuals as seeking attention, approval, support, and affection in the context of their interactions with others. Not surprisingly, *Hy1* correlates negatively with Welsh’s *A* scale (Anxiety) at $-.65$, suggesting unusual freedom from social anxiety and fear of embarrassment. Levitt (1989) described low scorers as socially maladjusted and anxious, shy, and easily embarrassed. It appears that *Hy1* taps the personality dimension of

social extraversion (when elevated) and social introversion (when submerged). Nichols and Greene suggested examining *Hy1* in the context of its relation to other measures of introversion to determine if the introversion is situational or long term. Specifically, when *Pd3* (Social Imperturbability), *Hy1*, and *Hy-S* are all low, they should be examined in relation to the *SOD* content scale, Scale 0, and Shyness/Self-Consciousness (*Si1*). Nichols and Greene (1995, p. 37) give the following configural guidelines for interpreting introversion as a state versus a trait:

High scores on *SOD*, *Si* and *Si1* when in the context of low scores on *Pd3*, *Hy1* and *Hy-S*, suggest long term or congenital trends toward shyness and social withdrawal. When *SOD*, *Si*, and *Si1* are high, but *Pd3*, *Hy1* and *Hy-S* are in an average range, an acute or temporary withdrawal secondary to loss or distress is suggested.

It should be noted that Wrobel (1992) did not find that social introversion was linked to *Hy1* per therapist ratings of clients in psychotherapy. He suggested that the short length of the subscale or the nature of the outpatient sample may have attenuated his results.

The six items on the *Hy1* subscale are all keyed False, making this subscale susceptible to an All-False response set. The item content essentially covers the extroversive component of Scale 3. Greene (2011) issued an important interpretative caveat by stating the highest possible *T*-score for *Hy1* is 61 (due to the scale's short length) in men and women. "In this instance, clinicians should consider a *T*-score of 56 on *Hy1* as being significant because the client has endorsed five of the six items on this scale" (Greene, 2011, p. 119).

Need for Affection (Hy2)

T-Scores > 65 are indicative of individuals who:

1. have strong needs for attention and affection from others and fear that those needs will not be met if they are honest about their feelings and attitudes
2. express naively optimistic and trusting attitudes towards others
3. claim to see others as honest, sensible, and reasonable
4. deny having negative feelings about other people
5. try to avoid unpleasant confrontations whenever possible

T-Scores < 40 are indicative of individuals who:

1. have very negative, critical, and suspicious attitudes toward other people
2. see others as dishonest, selfish, and unreasonable
3. admit to negative feelings toward other people
4. perceive that others are treating them badly

Hy2 (Need for Affection and Reinforcement from Others—12 items):

Harris and Lingoes state that this subscale reflects an “(obtuse) denial of a critical or resentful attitude toward other people; impunitiveness; overly protested faith and optimism in other people.” *Hy2* is the Pollyanna component of Scale 3. The items deny negative traits such as cynicism, mistrust, hostility, and rebellious attitudes, feelings, and impulses. It overlaps *CYN1* and *RC3* by five items each, scored oppositely. This subscale is closely related to *Pa3* ($r = .76$), with which it shares three items. However, whereas only three (33%) of the *Pa3* items begin with “I,” nine (75%) of the *Hy2* items do so. The *Hy2* items emphasize the denial of negative traits in the self; the *Pa3* items deny negative traits in others.

Thus, whereas the thrust of most of the *Pa3* items is that “*Most people* are virtuous and constructive,” the thrust of *Hy2* is that “*I* am virtuous and constructive.” The low level of cynicism connoted in high *Hy2* scores implies the kind of impunitive detachment and naive lack of normal skepticism of the motives of others that some may view as immature and unrealistic. In the aggregate, these items suggest strong needs for approval, or at least an abnormally strong aversion to giving offense or to drawing negative attention from others. A high score reflects an overly gracious and beguiling style of relating to others and apparent blind trust in their integrity and innocuousness, suggesting passivity/dependency, the lack of a sense of personal power, and an unnecessarily roundabout style when it comes to seeking affection. *Hy2* is strongly correlated with *K* ($r = .77$) and, negatively, with *CYN* ($-.84$) and *CYN1* ($-.83$).

Hy2 is the Pollyanna component of Scale 3. The items appear to emphasize a faith and trust in people, and reflect a denial of resentment or suspicion toward others (Caldwell, 1988; Greene, 1991a, 2000; Wrobel, 1992). The items also reflect a denial of hostility, rebellious attitudes, feelings, and impulses. It appears that high scorers prefer to avoid interpersonal conflict. Graham et al. (1999) found their high scoring *Hy2* outpatient men and women to be more empathic than low scorers, and this correlate was unique to *Hy2* among the *Hy* subscales. They also reported that high scoring women were seen as moralistic by their therapists. There is a strong element of unconflicted passivity and submissiveness in *Hy2* which reflects a “go along to get along” social spirit according to Nichols and Greene (1995, p. 40), wherein high scorers believe that the consequences of self-assertion are generally not socially constructive: High scorers seem to believe that, if one thinks the best of others, others will oblige by behaving in

accordance with a benign and benevolent set of expectations, and that argument, disagreement, challenge, and confrontation are to be rejected because they can only serve to make social relations unpleasant, create hurt feelings, and foster alienation.

They also view *Hy2* as related to an aspect of cynicism, with low scorers “disclaiming self-traits of trustworthiness and social constructiveness” (Nichols & Greene, 1995, p. 33). Caldwell (1988) described low scorers as perceiving the world as “combative” (p. 19) where one has to take care of oneself and fight for what one wants and believes. Eleven of the 12 items on *Hy2* are keyed False, with only 1 item keyed True, making it vulnerable to the influence of an All-False response set. *Hy2* is closely related to *Pa3*— Moral Virtue ($r = .76$), with which it shares three items. Three (33 percent) of the *Pa3* items begin with “I,” whereas nine (75 percent) of the *Hy2* items do so. The *Hy2* items emphasize the denial of negative traits in the self; the *Pa3* items deny negative traits in others. Thus, Nichols (2011, p. 111) states, whereas: ...the thrust of most of the *Pa3* items is that “Most people are virtuous and constructive,” the thrust of *Hy2* is that “I am virtuous and constructive.” The low level of cynicism connoted in high *Hy2* scores implies the kind of impunitive detachment and naive lack of normal skepticism of the motives of others that some may view as immature and unrealistic. In the aggregate, these items suggest strong needs for approval, or at least an abnormally strong aversion to giving offense or to drawing negative attention from others. A high score reflects an overly gracious and beguiling style of relating to others and apparent blind trust in their integrity and innocuousness, suggesting passivity/dependency, the lack of a sense of personal power; and an unnecessarily roundabout style when it comes to seeking affection. *Hy2* is strongly correlated with *K* ($r = .77$) and, negatively, with *CYN* ($-.84$) and *CYN1* ($-.83$).

Lassitude Malaise (Hy3)

T-Scores > 65 are indicative of individuals who:

1. feel uncomfortable and not in good health
2. feel weak, fatigued, or tired
3. report difficulties in concentrating and sleeping
4. feel unhappy and blue
5. report that their home environments are unpleasant and uninteresting

T-Scores < 40 are indicative of individuals who:

1. report being comfortable and in good health
2. do not have difficulties in concentrating, sleeping, or poor appetite
3. feel happy and satisfied with their life situations

Hy3 (Lassitude-Malaise—15 items): “Complaints about functioning below par physically and mentally; effortful keeping up of a good front; need for attention and reassurance” (Harris and Lingoës). *Hy3* is the depressive component of Scale 3. Ten of its items overlap with Scale 2 ($r = .90$), eight with Scale 1 ($r = .88$), seven with *D1*, five with *D3*, three with *D4*, and one each with *D2* and *D5*. Four items overlap with *Pd4*. Not quite half of the items are somatic/health related, but most of these have clear depressive overtones. The somatic complaints tend to be vague rather than specific; see *Hy4*. Elevations connote a broad lack of vitality and physical discomfort without freedom from distress. The neurasthenic syndrome of weakness, tiredness, and easy fatigability is strongly represented in *Hy3*.

Harris and Lingoës (1968) reported the content for *Hy3* as “complaints about functioning below par physically and mentally; effortful keeping up of a good front; and need for attention and reassurance.” *Hy3* is clearly the depressive component of Scale 3 (Nichols, 2011). Five of the items on this subscale are keyed True, 10 False. Elevations connote “a broad lack of vitality and physical discomfort without freedom from distress. The neurasthenic syndrome of weakness, tiredness, and easy fatigability is strongly represented in *Hy3*” (Nichols, 2011, p. 112). Not quite half of the items are somatic/health related, but most of these have clear depressive overtones. The somatic complaints tend to be vague rather than specific.

Although 10 of the 15 items on this scale overlap with Scale 2 ($r = .90$), Caldwell (1988) suggested that the scale taps less of the generalized devaluation of the self that is seen in depression, and is more of a measure of having been made to feel weak, tired, sleepless, and less interested in life by life’s aggravations or one’s own poor health. High scorers report not feeling like themselves physically and mentally. Nichols and Greene (1995) described *Hy3* as reflecting some depressive somatization, like *D3* (Physical Malfunctioning) with which it shares five items, but having a greater emphasis on moods than on somatic difficulty. In a sample of psychotherapy patients, Wrobel (1992) found that complaints about physical and mental functioning, and feelings of needing attention and reassurance, positively correlated with elevated *Hy3* scores, whereas efforts to keep up a good front negatively correlated with *Hy3* scores. Graham et al. (1999) found high scoring *Hy3* psychiatric men and women outpatients to have suicidal ideation.

Prokop (1986) investigated the Harris-Lingoës subscale patterns for Scale 3 in a lowback pain sample. Prokop (1986, 1988) recommended that *if Hy3 and Hy4 are elevated (but not Hy1, Hy2, and Hy5), in a low-back pain population,*

it may be appropriate to describe the individual as abnormally focusing on his or her physical symptoms. It should be noted that *Hy1*, *Hy2*, and *Hy5* all overlap with Little and Fischer's (1958) *Dn*. Prokop (1988) cautioned against inferring the presence of conversion dynamics when only *Hy3* and *Hy4* are elevated in low-back pain patients, stating that the patient may be attempting to express his or her distress about confusing or frightening symptoms. Such patients are often diagnosed with a non-conversion-based somatoform disorder. Consistent with Prokop's (1988) contention of an abnormal focus on one's bodily functioning is Greene's (2011) description of *Hy3* having 14 of its 15 items in common with the Little and Fischer *Ad* scale. As noted earlier, Little and Fischer suggested that conversion reaction dynamics should be suspected if both the *Dn* and *Ad* scales are elevated.

Somatic Complaints (*Hy4*)

T-Scores > 65 are indicative of individuals who:

1. present multiple somatic complaints
 - a) pain in the heart and/or chest
 - b) fainting spells, dizziness, or balance problems
 - c) nausea and vomiting
 - d) poor vision
 - e) shakiness
 - f) feeling too hot or too cold
2. express little or no hostility toward other people

T-Scores < 40 are indicative of individuals who:

1. do not report somatic complaints
2. admit to hostile and aggressive impulses

Hy4 (Somatic Complaints—17 items): Harris and Lingoes describe these items as being "Of a kind that suggest repression and conversion of affect." *Hy4* is the somatic component of Scale 3. Twelve of its items overlap Scale 1 ($r = .94$), and 13 overlap *HEA* (.94) and *RC1* (.94); six overlap *HEA2* (.89). Only two items overlap *Sc6*, but the scales are highly correlated (.80). The items refer to symptoms that are fairly discrete and dramatic; specific complaints outnumber vague complaints in a ratio of about 3:1 and emphasize head complaints, pain and discomfort, and vascular and

cardiorespiratory problems. About half of the items refer, implicitly or explicitly, to spells or attacks. Just over half of the symptoms lend themselves to iconic or metaphoric use, especially through wording like, “lump in my throat,” “attacks of nausea,” “feeling hot all over,” “pains over my heart,” “my muscles twitching,” “a tight band around my head,” “dizzy spells,” “my hand shakes,” “my heart pounding,” and so forth. The language of these items is more dramatic—even flamboyant—than is typical for the somatic portion of the MMPI-2 item pool. These items have an arresting quality and are subject to colorful elaboration on interview. That is, they are easily pressed into service as components of a story that the patient wishes to relate, and one that is likely to have a relatively easily discernible latent message. There is much less implied distress in *Hy4* than in *Hy3*; hence *Hy4* greater than *Hy3* suggests a working conversion with probable *la belle indifference*, provided *Hy4* is not too high. However, at about five to seven raw items, *Hy4* begins to suggest somatization over conversion, regardless of the *Hy4–Hy3* difference.

Harris and Lingoes (1968) characterized the *Hy4* items as being “of a kind that suggest repression and conversion of affect.” Six of the items are keyed True, 11 False. As the somatic conversion component of Scale 3 (Caldwell, 1988), it is not surprising that it is highly correlated with Scale 1 (*Hy*) at $r = .88$ (Caldwell, 2007b, as reported in Greene, 2011). Twelve of the *Hy4* 17 items are scored on Scale 1 (*Hy*) and three overlap HEA. *Hy4* correlates highly ($r = .79$) with *Hy* in the Caldwell (2007) clinical sample. The five items that are not scored on Scale 1 have elements of anxiety (e.g. fainting spells and “lump in my throat”) that are in noteworthy contrast to the reporting of somatic dysfunction, without the explicit anxiety that characterizes Scale 1 (Caldwell, 1988, p. 20). Graham

et al. (1999) reported that 17 percent of 305 psychiatric women outpatients who scored above $T = 65$ on *Hy4* reported current anxiolytic medication usage. Greene (1991a) pointed out that 16 of the 17 items in this scale overlap with Little and Fischer’s (1958) *Ad*, and that *Ad* correlates positively ($r = .89-.90$) with Scale 1. With the exception of item 18, which reports attacks of nausea and vomiting, the only items missing from *Hy4* (and Scale 3) that appear on Scale 1 relate to gastrointestinal complaints. Whereas Scale 1 and the *HEA* content scale represent general physical complaints, *Hy4* (and *Hy-O*) emphasize specific, as opposed to vague, symptoms (Nichols & Greene, 1995). Low scores should be interpreted as reflecting a person free of excessive somatic concerns.

Nichols (2011, p. 112) provides a description of the *Hy4* content: The items refer to symptoms that are fairly discrete and dramatic; specific complaints outnumber vague complaints in a ratio of about 3:1 and emphasize head complaints, pain and discomfort, and vascular and cardiorespiratory problems. About half of the items refer, implicitly or explicitly, to spells or attacks. Just over half of the symptoms lend themselves to iconic or metaphoric use, especially through wording like, “lump in my throat,” “attacks of nausea,” “feeling hot all over,” “pains over my heart,” “my muscles twitching,” “a tight band around my head,” “dizzy spells,” “my hand shakes,” “my heart pounding,” and so forth. The language of these items is more dramatic—even flamboyant—than is typical for the somatic portion of the MMPI-2 item pool. These items have an arresting quality and are subject to colorful

elaboration on interview. That is, they are easily pressed into service as components of a story that the patient wishes to relate, and one that is likely to have a relatively easily discernible latent message. There is much less implied distress in *Hy4* than in *Hy3*; hence, *Hy4* greater than *Hy3* suggests a working conversion with probable la belle indifference, provided *Hy4* is not too high. However, at about five to seven raw items, *Hy4* begins to suggest somatization over conversion, regardless of the *Hy4-Hy3* difference.

Inhibition of Aggression (Hy5)

T-Scores > 65 are indicative of individuals who:

1. deny hostile and aggressive impulses
2. report they are not interested in reading about crime/violence
3. are sensitive about how others respond to them

T-Scores < 40 are indicative of individuals who:

1. admit to hostile and aggressive impulses
2. express interest in reading about crime/violence
3. are not concerned about how others view them

Hy5 (Inhibition of Aggression—7 items): This brief subscale lacks internal consistency and appears to have been inaptly named. Harris and Linges noted that the inhibition of aggression is “expressed by concurrence with others, disavowal of violence.” Only one of the items (29) fits the label at all well (but see *D-O*, *D2*, and especially *Dr2*). Judging from its correlations with *R* (.39) and *DISC* (–.28), such inhibitions as there may be appear to be biased toward the emotional. *Hy5* is only moderately to weakly related to measures of aggression (e.g., *AGGR*, –.27), anger (e.g., *ANG*, –.45), and hostility (e.g., *TPA2*, –.33); it does not appear adequate for contributing to judgments about aggression or the inhibition thereof. However, at least three of the items appear to reflect distaste, abhorrence, revulsion, or noninterest in *vicarious* violence and aggression. Thus, the high *Hy5* scorer seems to be saying that crime news, detective stories, swearing, the sight of blood, and so on are morbid and disgusting (“icky”) and are implicit threats to the patient’s sensory inhibition. *Hy5* is moderately correlated with *K* (.46). Low scores may suggest interest or even morbid fascination with violence, but the scale is a weak basis for clinical inferences.

Purportedly, this brief seven-item scale reflects the inhibition or suppression of aggression, irritability, and anger in emotional life and fantasy. All seven of the items are keyed False, making it vulnerable to an All-False response set. Regardless of high or low scores, the scale is a weak basis on its own for making clinical inferences. Harris and

Lingoes (1968) noted that the inhibition of aggression is “expressed by concurrence with others, disavowal of violence.” The scale lacks internal consistency, and only one item (item 29) appears to fit the scale title well (Levitt, 1989; Nichols, 2011).

Judging from its correlation with *R* (.39) and *DISC* (–.28), such inhibitions as there may be appear to be biased toward the emotional. *Hy5* is only moderately-to-weakly related to measures of aggression (e.g. *AGGR*, –.27), anger (e.g. *ANG*, –.45) and hostility (e.g. *TPA2*, –.33); it does not appear adequate for contributing to judgments about aggression or the inhibition thereof. (Nichols, 2011, p. 112)

Nichols and Greene (1995) explained that although *Hy5* moderately correlates with measures of denial, anger or hostility, it “appears to operate more as a disgust with anger and hostility than a denial scale per se” (p. 30). At least three of the items appear to reflect distaste, abhorrence, revulsion, or noninterest in vicarious violence and aggression. Thus, the high *Hy5* scorer seems to be saying that crime news, detective stories, swearing, the sight of blood, and so on are morbid and disgusting and are implicit threats to the person’s sensory inhibition (Nichols, 2011). Caldwell (1988) reported that high scorers “get upset” by aggression in others and have a “hysteroid abhorrence of violence” (p. 20) that is likely to be quite prominent if *Hy5* is elevated with a high Scale 5 (*Mf*) score in the “feminine” direction by men or women.

Low scores suggest an ability to experience anger directly; in fact, very low scores (e.g. raw score of zero or one) suggest an interest or fascination with anger or violence and its potential consequences, as well as a lower threshold for experiencing morbid or violent fantasies. Very low *Hy5* scores may particularly indicate hostility when accompanied by elevations on *ANG2* (Irritability), *TPA1* (Impatience), and *TPA2* (Competitive Drive; Nichols & Greene, 1995). It is important to note other indicators of impaired empathy when *Hy5* is very low, such as the particular code pattern and other measures (e.g. *ASP1* and *CYM*). The item content of *Hy5* is subtle, with six of its seven items overlapping *Hy-S*.

Scale 3: Subtle–Obvious Subscales

Hy-O (Hysteria–Obvious—32 items): *Hy-O* contains 32 items and encompasses *Hy3* and *Hy4*. *Hy-O* is highly correlated with *Hs* (.96), *HEA* (.92), *D-O* (.92), *Pt* (.84), *Sc* (.83; *Sc4*, .81; *Sc6*, .79), *ANX* (.83), and *DEP* (.80), and moderately with *K* (–.55). This subscale is highly saturated with the First Factor (correlation with *A* = .78) and thus will be raised by any of the distress scales.

Hy-S (Hysteria-Subtle—28 items): *Hy-S* contains 28 items and encompasses subscales *Hy1*, *Hy2*, and *Hy5*. It is highly correlated with *K* (.82) and negatively with *CYN* (–.79; *CYN1*, –.77) and *A* (–.70). *Hy-S* scores, then, will be increased by *K* and will, in turn, suppress scores on Scales 7, 8, and 0.

The Hysteria-Obvious subscale (*Hy-O*) has 32 items, of which 12 are keyed True, 20 False; and Hysteria-Subtle (*Hy-S*) has 28 items, of which 27 are keyed False, 1 True. The items, direction of scoring, and *T*-score conversions can be found in Friedman et al. (2001).

The *Hy-O* items appear to emphasize specific, as opposed to vague, symptoms (Nichols & Greene, 1995). In fact, as Caldwell (1988) indicated, the composition *Hy-O* is almost identical to *Hy3* and *Hy4*, as well as Little and Fischer's (1958) *Ad*. The numerous physical concerns reflected in *Hy-O* include some items related to the construct of hysteria, such as fainting spells and hand tremors. *Hy-O* reflects somatic problems and discomforts that may also antagonize normal sleep (Nichols & Greene, 1995).

A low score contraindicates depleted energies due to physical discomfort and distress. *Hy-O* is highly correlated with *Hs* (.96), *HEA* (.92), *D-O* (.92), *Pt* (.84), *Sc* (.83; *Sc4*, .81; *Sc6*, .79), *ANX* (.83), and *DEP* (.80), and moderately with *K* (–.55). This subscale is highly saturated with the first factor (correlation with *A* = .78) and thus will be raised by any of the distress scales (Nichols, 2011).

Dahlstrom (1991) derived correlates for *Hy-O* from partner ratings on the Katz Adjustment Scales (Butcher et al., 1989) in the re-standardization sample. Men and women with high *Hy-O* scores were described as having trouble sleeping; worrying about their health; lacking energy and appearing worn out; lacking an interest in things; not appearing self-confident, cheerful, or pleasant; and complaining about body aches and ailments. Women in particular were seen as restless, self-blaming, worried about the future, and feeling like others do not care about them. Men in particular were seen as having a poor sense of humor; getting easily upset by small, unexpected events; having difficulty making decisions; lacking ambition; and not willing to try new things. Caldwell (1988) pointed out that *Hy-S* is very similar in item content to the *Hy1*, *Hy2*, and *Hy5* subscales, as well as virtually identical to Little and Fischer's (1958) *Dn*.

Nichols and Greene (1995) viewed *Hy-S* as measuring a subtle and complex disposition to claim freedom from problems in adaptation, hostile feelings and impulses, cynicism and distrust, and social discomfort. An elevated *Hy-S* score usually is not the result of an intentional effort to mislead the psychologist. Nichols and Greene (1995, p. 34) generated several hypotheses for an elevated *Hy-S* score (as well as an elevated *K* score):

These elevations may be the product of honest but erroneous self-appraisal (selfdeception); above-average adjustment, resourcefulness and resiliency; or a social advantage that confers protection or insulation from major

stresses or challenges to adjustment such as great wealth, high socioeconomic status, or a close, active, and committed circle of friends or family.

They also pointed out that the full *Hy* scale is a somewhat less satisfactory measure of the repression construct than *Hy-S*, mostly because of the dysphoric content in *Hy3*. *Hy-S* is highly correlated with *K* (.82) and negatively with *CYN* (-.79; *CYN1*, -.77) and *A* (-.70). *Hy-S* scores, thus, will be increased by *K* and will, in turn, suppress scores on Scales 7, 8, and 0 (Nichols, 2011).

Low *Hy-S* scores are likely to indicate mild cynicism. Admission to feeling somewhat beleaguered, uncomfortable with strangers, and having a view of the world as antagonistic would also characterise low scorers.

Dahlstrom (1991) provided the following correlates for the *Hy-S* subscales. Both men and women are perceived as being self-confident, lacking shyness, willing to try new things, getting along well with others, not being suspicious of or avoiding others, friendly, and not lacking in emotional control. Women in particular were rated as not getting very sad or bored, not lacking in energy or having many fears, being able to laugh with others, not worrying about the future, and not getting their feelings easily hurt. Men were described as not arguing about minor things, being constructive or helpful, affectionate, generous, not bossy, cooperative, and not demanding attention.

04 – Pd – Psychopathic Deviance

Scale 4 (Pd)

1) 50 items which assess a **lack of concern about most social and moral standards of conduct**

a. *Examples 54. My family does not like the work I have chosen (or the work I intend to choose for my life work). (T)*

79. I do not mind being made fun of. (F)

2) scale developed on individuals who were referred to a psychiatric service for a clarification of why they had recurring troubles with the law even though they suffered no cultural deprivation and did not possessing normal intelligence and freedom from other psychological disorders

a. tried to get at the Conduct Disorder/Antisocial Personality Disorder folks

b. not too sure they made it



1. standardization with gangs?

3) Harris-Lingoes Subscales

- a. familial discord
- b. authority problems
- c. social imperturbability
- d. social alienation
- e. self-alienation

As previously noted, the Harris-Lingoes subscales can help identify the particular pattern of item content that characterizes a high score on the MMPI-2 parent scale. Scale 4 is particularly well served by a subscale pattern analysis as the scale is rich and varied in its content. Several *Pd* subscales assess very different aspects of psychopathy; consideration of these differences may have significant implications for clinical practice and assessment (Lilienfeld, 1999). Harris and Lingoes (1955) developed five subscales for Scale 4: Familial Discord (*Pd1*), Authority Problems (*Pd2*), Social Imperturbability (*Pd3*), Social Alienation (*Pd4*), and Self-Alienation (*Pd5*). Unlike the majority of Harris-Lingoes subscales that were unaffected by the MMPI-2 revision, several item changes and deletions on the *Pd* subscales have compromised the consistency between the MMPI and MMPI-2 for these subscales (Chojnacki & Walsh, 1994). In their original construction, Harris and Lingoes, for unexplained reasons, added from two to six items to each of the *Pd* subscales taken from an unpublished earlier version of Scale 4 (Greene, 2011; Levitt, 1990). For reasons that are likewise unclear, the MMPI-2 revision deleted these items. The only rationale provided was that these items were not included in the final version of Scale 4 (Butcher et al., 1989, p. 29), but questions about the possible advantages of retaining these “off-scale” items on the basis of their content or their contribution to enhanced subscale reliability were not addressed. In examining the consistency between the original MMPI and the MMPI-2, Chojnacki and Walsh (1994) concluded that the shortened *Pd* subscales do not materially affect the *T*-scores for these subscales. *Pd1*, *Pd2*, *Pd3*, *Pd4*, and *Pd5* lost two, three, six, five, and three items, in the re-standardization, respectively. The Harris-Lingoes subscales for Scale 4 contain minimal overlap; three items overlap *Pd4* and *Pd5*.

4) **T-Scores > 65 are indicative of persons who:**

- a. have difficulty incorporating values and standards of society into their lives
 - b. may engage in social and antisocial acts, including lying, cheating, stealing, sexual acting out, excessive use of alcohol and/or drugs
1. especially if T-Score > 75

- c. are rebellious toward authority figures
- d. have stormy relationships with their families
- e. blame family members for their difficulties
- f. have histories of underachievement
- g. tend to experience marital problems
- h. are impulsive and strive for immediate gratification of impulses
- i. do not plan their behavior well
- j. tend to act without considering the consequences of their actions
- k. are impatient; have limited frustration tolerance
- l. show poor judgment; take risks
- m. tend not to learn from experience
- n. are seen by others as immature and childish
- o. are narcissistic, self-centered, selfish, and egocentric
- p. are ostentatious and exhibitionistic
- q. are insensitive to the needs and feelings of others
- r. are interested in others only in terms of how they can be used
- s. are likable and create good first impressions
- t. have shallow and superficial relationships
- u. seem unable to form warm attachments with others
- v. are extroverted and outgoing
- w. are talkative, active, adventurous, energetic, and spontaneous
- x. are judged by others to be intelligent and self-confident
- y. have a wide range of interests but lack a clear direction
- z. tend to be hostile, aggressive, resentful, rebellious, antagonistic, and refractory
- aa. have sarcastic and cynical attitudes
- ab. may act in aggressive ways
- ac. if female, may express aggression in more passive, indirect ways
- ad. may feign guilt and remorse when in trouble
- ae. are not seen as overwhelmed by emotional turmoil
- af. may admit feeling sad, fearful, and worried about the future
- ag. experience absence of deep emotional response
- ah. feel empty and bored

- ai. if psychiatric patients, are likely to receive antisocial or passive-aggressive personality disorder diagnoses
- aj. have poor prognosis for psychotherapy or counseling
- ak. may agree to treatment to avoid something more unpleasant
- al. tend to terminate therapy prematurely
- am. in treatment, tend to intellectualize excessively and to blame others for their difficulties

5) T-Scores 58-64 (moderate elevation) are indicative of individuals who:

- a. may be genuinely concerned about social problems and issues
- b. may be responding to situational conflicts
- c. may have adjusted to a habitual level of interpersonal and social conflict
- i. if the conflict is situational, the score should return to normal levels once the conflict is resolved

6) Normal range: T-Scores 40-57

7) T-Scores < 40 are indicative of individuals who:

- a. tend to be conventional, conforming, and accepting of authority
- b. are passive, submissive, and unassertive
- c. are concerned about how others will react to them
- d. tend to be sincere and trusting in relationships
- e. have a low level of drive
- f. are concerned about status and security but tend not to be competitive
- g. have a narrow range of interests
- h. are not creative or spontaneous in their approach to problems
- i. are persistent in problem solving
- j. are moralistic and rigid in their views
- k. if males, may not have much sex drive
- l. are self-critical and dissatisfied with self
- m. accept advice and suggestions
- n. may become overly dependent on treatment
- o. seem to be afraid to accept responsibility for their own behavior

T > 75 Antisocial behavior; trouble with the law

T = 65---74 Rebellious, non---conforming; family problems; impulsive, angry, irritable, dissatisfied; creative; underachievement; poor work history

T=55---64 unconventional; immature, self---centered; superficial relationships; extroverted, energetic

T = 45---54 Average score; no interpretation

T < 45 Low score; no interpretation

Harris---Lingoes

Pd1 – Familial Discord

Pd2 – Authority Problems

Pd3 – Social Imperturbability

Pd4 – Social Alienation

Pd5 – Self---Alienation

>75 - angry rebelliousness against social mores, shallow, hostile, and manipulative interpersonal relationships, inability to profit from experience or plan ahead, anger at family, antisocial behavior, moodiness, personality disorders, substance abuse, sexual immorality, aggressive outbursts, immaturity, exhibitionism, use projection
65-75 - authority problems

Pd1 - Familial discord - perception of family as unsupportive, distressing, or abusive

Pd2 - Authority problems - assertive, opinionated, rebellious, in trouble at school or with the law

Pd3 - Social imperturbability - socially skilled, seek interaction, are assertive, deny dependency

Pd4 - Social alienation - feel lonely, are self-centered, unhappy, project responsibility, externalize conflicts

Pd5 - Self-alienation - agitated, unhappy, guilt, lack of self-integration, poor concentration, may be alcohol abuse
norm – interpersonally adequate, sincere, concerned for others

very low - conforming, rigid, follow authority, tolerate boredom and mediocrity,

males often show lack of interest and mistrust of females

Scale 4 is a heterogeneous scale, so not all individuals obtaining high Scale 4 scores are necessarily antisocial or act out aggressively. Scale 4 elevations can be obtained by individuals currently experiencing alienation due to a divorce or other emotional setbacks to which they have responded by “emotional numbing.” They may also be feeling anger and bitterness that is externalized. However, all individuals with Scale 4 elevations do exhibit behaviors and traits in common. Generally, they dislike rules being imposed on them, are cautious about allowing themselves to become emotionally close to others, and consequently experience problems with the trust and vulnerability required of intimacy. They dislike being controlled and yet tend to be somewhat dependent. All high Scale 4 persons can be manipulative to varying degrees and capable of selectively reporting in order to get their needs met. Although

needing reassurance, they tend not to trust it. They show deficits of empathy and protect themselves against being vulnerable to getting hurt. Not all individuals elevated on Scale 4 necessarily overtly resist authority, although many do. SES is an important variable in how the traits and behaviors measured by Scale 4 are expressed. Educated and bright individuals with high scores on Scale 4 can act out, but often do so in controlled, deliberate, self-serving ways. In some cases they may commit white-collar crimes, such as a stock manipulator who pushes the limits of legality beyond “gray areas.” It is likely that some of the individuals involved in the events leading to the financial crisis of 2008 manifested Scale 4 attributes. Bending the rules, pushing limits, and looking for immediate gratification, they exhibited classic high Scale 4 behaviors and personality traits. A history of acting-out behavior, rebelliousness, anger towards authority, and emotional and social alienation would suggest that a current Scale 4 elevation is characterological. In the absence of such a history and in the presence of a current or recent stressful and alienating situation, a Scale 4 elevation could reflect a situational adjustment reaction of adult life. However, even though these may not be enduring traits, an individual experiencing an adjustment reaction with Scale 4 elevated will manifest alienation, externalized anger, difficulties with emotional self-regulation, and lack trust in others.

High scores ($T > 65$) reflect externalized anger, irritability, and a resistance to being controlled. This anger may be turned against family, society in general, or both. The manner in which antisocial or asocial impulses are expressed depends upon the elevations of other scales. If Scale 9 is elevated, the individual's initial easygoing charm and glib banter can quickly become confrontational, demanding anger, whereas if Scale 8 is elevated, the acting out is senseless and self-defeating, even bizarre. Characterologically high Scale 4 individuals show impulsiveness, poor judgment, unpredictability, social alienation, and a lack of responsibility and conscience. They lack empathy and evidence poor work and marital adjustment. They sacrifice long-term goals for short-term desires and have difficulty anticipating consequences. Strong loyalties rarely develop. They can make a good first impression, but have difficulty with sustained perseverance towards goals. Not all attributes of Scale 4 are necessarily undesirable. They tend to question the established way of doing things, are willing to question authority, and often are quite adventurous. The concept of “thinking outside the box” that has been a hallmark of creativity is something that they tend to do instinctively. Substance abuse tends to be associated with high Scale 4 and increases their propensity for impulsive and poorly thought through behavior.

For individuals beyond age 40 with a high Scale 4 lifestyle, an elevated Scale 4 reflects longstanding interpersonal disaffiliation and antisocial behavior, whereas for individuals over age 60, high scores suggest alienation to the point of a sullen lack of emotional involvement.

Moderately high elevations ($T=55-65$) are associated with adrenaline seeking, independent thinking and subtle demandingness, as well as difficulties with emotional intimacy and a tendency to selectively report. Even in the relatively normal range, a Scale 4 elevation would predict that irritability and selective reporting readily occur under stress. In this range, for example, a person could rationalize telling white lies to “protect others” from the truth and subtly manipulate people into doing “what is good for them anyways.”

Moderately low to very low scores ($T < 45$) are associated with conventionality, stability, and unassertiveness to the point of passivity. These individuals are not adventurous and often dependent and comfortable with routine. They generally do not question authority even when they find it onerous. They tend to not be sexually aggressive and are seen by others as reliable and stable.

Number of Items: 50

True/False Balance: 24/26

Overlap: 10 items with Scales 3 and 8, 9 with *RC4*, 8 with Scale 6, 7 with Scale 2, 6 with Scales 7 and 9 and *DEP* and *FAM*, 5 with Scale 0 positively and 6 items scored negatively, and 5 with *DISC*.

Content: Family conflict, antisocial behavior and attitudes, social fearlessness, social alienation, and unhappiness, dissatisfaction, and guilt.

Relations with Other Scales: The interpretation of Scale 4 is heavily dependent on its relationships with other scales in the profile. Among the basic clinical scales, Scale 4 is most highly correlated with Scales 8 at .76 and 7 at .73. Content scale correlates of Scale 4 include *DEP* (.76) and *FAM* (.73). The correlation with *RC4* is .64. These relationships are determined by *Pd-O* and by the fact that these correlates are drawn from a psychiatric sample; in this sample, the correlation between Scale 4 and *Pd-O* is .92, whereas that with *Pd-S* is only .37. This pattern of correlations would be substantially different in a correctional sample and somewhat different in a normal sample.

Familial Discord (Pd1)

T-Scores > 65 are indicative of individuals who:

1. describe their home and family situations as quite unpleasant
2. describe their current families and/or families of origin as lacking in love, understanding, and support
3. feel their families have been critical

4. feel their families refuse to give them adequate freedom and independence

T-Scores < 40 are indicative of individuals who:

1. describe their home and family situations in very positive terms
2. see their families as offering love, understanding, and support
3. describe their families as not being overly controlling or domineering

Pd1 (Familial Discord—9 items): “Struggle against familial control” (Harris and Lingo). *Pd1* operates largely as a content scale, reporting problems and conflicts biased toward the family of origin. It has six items in common with *FAM*, three on *FAM1* and two on *FAM2*. Considerable bitterness and resentment and some projection of blame are implicit in many of the items. There is a sense of injury implicit in *Pd1* that may be the result of being controlled and disapproved of while not feeling cared for. *Pd1*, along with *Pd4* and *Sc1*, is one of the subscales most sensitive to the history of abuse, both for victims and for perpetrators.

The items in this subscale reflect current and historical problems with one’s family and the accompanying feeling that one wishes to escape a loveless home (Caldwell, 1988).

Five of the *Pd1* items keyed True, four False. *Pd1* has six items in common with *FAM*, three on *FAM1*, and two on *FAM2*. Levitt (1989) reported that high scorers reject a family situation that they consider affectionless, stressful, and lacking in emotional support. Wrobel’s (1992) study of clinician descriptions for *Pd1* elevations showed feelings of struggle against family control to be significant. Graham et al. (1999) reported that high scoring psychiatric outpatient women on *Pd1* tended to blame their families for their difficulties, demanded much attention, and appeared argumentative. Given the item content for this subscale, it is not surprising that Pancoast and Archer (1988) found that adolescents, in contrast to adults, are particularly likely to endorse *Pd1* items. Nichols and Greene (1995) report that *Pd1* is biased toward conflict and alienation in the family of origin and viewed it as a general measure of family alienation. In fact, when *F*, *Sc1* (Social Alienation), and *Pd1* are all elevated, there is a good likelihood of the respondent making explicit statements concerning hatred toward one or both parents.

Nichols

(2011) described the item content in this subscale as reflecting considerable bitterness and resentment toward one’s family of origin. “There is a sense of injury implicit in *Pd1* that may be the result of being controlled and disapproved of while not feeling cared for” (p. 123). *Pd1* as well as *Pd4* and *Sc1* are subscales which are sensitive to a history of abuse, both for victims and for perpetrators. Caldwell (1988) reported that low scores reflect a supportive family with genuine compatibility and strong ties or possibly a need to minimize and deny family problems.

Authority Problems (Pd2)

T-Scores > 65 are indicative of individuals who:

1. resent societal and parental standards and customs
2. admit to having been in trouble in school or with the law
3. have definite opinions about what is right and what is wrong
4. stand up for their own beliefs
5. are not greatly influenced by the standards and values of others

T-Scores < 40 are indicative of individuals who:

1. tend to be very socially conforming and accepting of authority
2. do not express personal opinions or beliefs openly
3. are easily influenced by other people
4. deny having been in trouble in school or with the law

Pd2 (Authority Conflict—8 items): “Resentment of parental and social demands, conventions and standards” (Harris and Lingoes). *Pd2* items are heterogeneous, but most share a common theme of rebelliousness and resistiveness or a sense of chafing under the constraints of authority, custom, or propriety. Major themes include historical acts of generally minor rule breaking or delinquency, rebelling against authority or conformist pressures, and argumentativeness. *Pd2* predicts behavioral undercontrol and reactive defiance to demands made by others and is a good measure of misbehavior and rule-breaking. It can be usefully compared with *Ma4*, with which it is essentially uncorrelated. When both are elevated, issues of control avoidance, autonomy, and self-determination may be prominent.

The content of *Pd2* reflects an opposition to authority figures (reactive defiance), dislike of school, rebelliousness, a lack of constraint and a resistiveness or a sense of chafing under the constraints of custom or propriety. Two items on *Pd2* are keyed True, six

False. The heterogeneous items have a strong historical bias, with an emphasis on past delinquent behavior, legal involvement, and trouble with authority. This may account for why they seem not to be suppressed by elevated *K* scores (Caldwell, 1988). Lilienfeld (1999) found *Pd2* to be more highly correlated than other *Pd* subscales with most indexes of antisocial behavior, a finding that is not surprising, given that several items refer explicitly to illegal

actions. He also reported that *Pd2* may be the better marker of primary psychopathy as compared with the other *Pd* subscales, a finding generally consistent with those of Meloy and Gacono (1995) and Graham et al. (1999). Similarly, Osberg and Poland (2001) found *Pd2* related to a criminal history.

High scores reflect a lack of behavioral control or impulsivity, either in the form of “clear violations of social norms and rules or attitudes that clearly suggest a lower threshold for behavior that violates rules and brings one into conflict with others, especially those in authority” (Nichols & Greene, 1995, p. 27). Wrobel (1992) found the descriptor “resents demands and convention of parent and/or society” to apply to his sample of outpatients scoring high on *Pd2*. Levitt (1989) described high *Pd2* scorers as rebellious and having difficulty accepting standards of behavior that impose responsibilities and interfere with personal gratification.

The clinician should take note of elevated *Pd2* scores, especially if elevated with other indicators of social disinhibition, such as the *ASP* content scale or its component subscale, Antisocial Behavior (*ASP2*). *Pd2* and *ASP2* imply the direct expression of antisocial conduct, but the prediction of antisocial behavior is higher when *ASP2* is greater than *Pd2*, *Pd2* is greater than *ASP*, and *ASP* is greater than *CYN* (Cynicism; Nichols & Greene, 1995). It should be noted that *Pd2* and *ASP* share three items. Misbehavior and rulebreaking are measured by *Pd2*, but it is prudent to compare this subscale score with ego inflation (*Ma4*). “When both are elevated, issues of control avoidance, autonomy, and self-determination may be prominent” (Nichols, 2011, p. 124). Graham et al. (1999) found that psychiatric men and women outpatients who scored high on *Pd2* reported recent alcohol and substance abuse and dependence problems. This finding is consistent with the above description of impulsive individuals with low frustration tolerance.

Low *Pd2* scorers do not admit to having difficulties with authority and tend to be socially conforming. They have a capacity for constraint that high scorers lack, and this may reflect a “mature submission to the rules and regulations that make for a sense of community with orderly and harmonious social relations among citizens” (Nichols & Greene, 1995, p. 40).

Social Imperturbability (Pd3)

T-Scores > 65 are indicative of individuals who:

1. present themselves as comfortable and confident in social situations
2. like to interact with others
3. experience no difficulty in talking with others

4. have strong opinions about many things and are not reluctant to defend these opinions vigorously

T-Scores < 40 are indicative of individuals who:

1. experience a great deal of discomfort and anxiety in social situations
2. do not like to meet new people
3. find it difficult to talk in interpersonal relationships
4. do not express personal opinions and attitudes openly

Pd3 (Social Imperturbability—6 items): “Denial of social anxiety; blandness; denial of dependency needs” (Harris and Lingoes). *Pd3* is the extroversive component of Scale 4 and is the shortest of the Scale 4 subscales. In addition to cutting its length by half, the restandardization committee’s elimination of the offscale items from Scale 4 increased the redundancy between *Pd3* and *Hy1* ($r = .90$), which now have two-thirds of their items in common. Both subscales connote an intrepid sociability. Four of the six *Pd3* items are contained within *Si1* ($r = -.85$), and three within *SOD2* (in both cases keyed oppositely), and three overlap with *Ma3*. The three offscale items dropped from the MMPI-2 version of *Pd3* combine with three of the remaining *Pd3* items to dominate the content of the seven-item *SOD2* component scale, but keyed in reverse. Thus the socially aggressive aspect of *Pd3* is also reflected in low *SOD2* scores. *Pd3* correlates negatively with *A* at $-.64$, suggesting unusual freedom from social anxiety and fear of embarrassment, as well as an assertive, counter-anxious attitude consistent with the image of the glib, smooth operator. *Pd3* is one of the *K*-correlated subscales ($r = .61$).

Originally a 12-item subscale, the removal of 6 items from the MMPI-2 version of *Pd3* left it with 6 items (shortest of the *Pd* subscales), all of which overlap *Pd-S*. *Pd3* reflects a strong extraversion tendency but without the need for affection and approval from others. All of the items are keyed False. Nichols and Greene (1995) stated that “*Pd3* reflects a highly aggressive and insouciant sociability consistent with a desire to use interpersonal relationships to manipulate, intimidate, exploit, and otherwise extract goods and services from others. There is little emphasis on social approval” (p. 37). There is a socially aggressive or impervious character to high *Pd3* scorers that is especially pronounced if signs of cynicism, hostility, and antisocial trends are present in the profile. High *Pd3* scorers (raw scores of five or greater on the MMPI-2) tend to be pushy and insensitive in their social interactions or even aggressive or overbearing (Nichols & Greene, 1995).

The Denial of Social Anxiety subscale (*Hy1*) and *Pd3* now share 67 percent of their items, making their interpretation similar. Both subscales connote an intrepid sociability. The elimination of six items in the MMPI-2

version of *Pd3* (because the items were not part of the final *Pd* scale) accounts for this increased proportion of item overlap. In effect, these two subscales reflect a social insensitivity that may constitute part of a narcissistic syndrome. Nichols (2011) emphasizes this narcissistic insensitivity by pointing out that the socially aggressive aspect of *Pd3* is also reflected in low *SOD2* scores. Consistent with this interpersonal style, Nichols states “*Pd3* correlates negatively with *A* at $-.64$, suggesting unusual freedom from social anxiety and fear of embarrassment, as well as an assertive, counter-anxious attitude consistent with the image of the glib, smooth operator” (Nichols, 2011, p. 124). Low *Pd3* scorers are likely to feel uncomfortable in social situations and experience difficulty taking social initiative. When *Pd3*, *Hy1*, and *Hy-S* are all low, and there are high scores on the *SOD* content scale, *Si*, and *Si2* (Social Avoidance), there may be long-term or congenital (temperamental) trends toward shyness and social withdrawal. If, however, *Pd3*, *Hy1*, and *Hy-S* are within normal limits, but *SOD*, *Si*, and *Si1* are significantly elevated, the individual may be experiencing a temporary social withdrawal in reaction to a loss or other distress (Nichols & Greene, 1995).

Social Alienation (Pd4)

T-Scores > 65 are indicative of individuals who:

1. feel alienated, isolated, and estranged
2. believe that other people do not understand them
3. feel they get a raw deal out of life
4. feel lonely, unhappy, and unloved
5. blame others for their own problems and shortcomings
6. are self-centered and insensitive to the needs and feelings of others
7. act in inconsiderate ways toward others

T-Scores < 40 are indicative of individuals who:

1. feel that they belong in their social environments
2. see other people as loving, understanding, and supportive
3. find interpersonal relationships gratifying

4. are willing to settle down; find comfort in the routine

Pd4 (Social Alienation—13 items): “Feelings of isolation from other people; lack of belongingness; externalization of blame for difficulties; lack of gratification in social relations” (Harris and Lingoes). *Pd4* is the paranoid component of Scale 4 but with some depressive undertones. It has six items in common with *Pa1* ($r = .79$) and three with *Pd5*. The primary theme of *Pd4* is social alienation: feeling apart, estranged, and misunderstood by others. Important secondary themes include resentment, deprivation, and dysphoria. Of these, deprivation may be the most important for understanding the high scorer on *Pd4*. Such patients often lacked an adequate holding environment in childhood. As adults, they carry a feeling of having been deprived, neglected and/or mistreated by others, and of their emotional needs having been trivialized and ignored.

Despite sharing the same label as *Sc1* (the two subscales have only three items in common), *Pd4* is different in several important ways from *Sc1* ($r = .78$). Whereas *Sc1* reflects a disinclination to form attachments to others, *Pd4* emphasizes an inability to do so, but with a sense of sorrow about this, unlike *Sc1*.

Among the standard clinical scales and subscales, *Pd4* is probably the most sensitive to severe childhood deprivation and neglect. High scorers have come to anticipate that others will withhold the interpersonal goods of affection, support, encouragement, and similar forms of emotional nourishment.

Harris and Lingoes (1968) described the *Pd4* content themes as “feelings of isolation, lack of belongingness, externalization of blame for difficulties, and lack of gratification in social relations.” Ten of the items are keyed True, three False. *Pd4* overlaps Scale 6 (*Pa*) by six items, all on *Pa1*, and three with *Pd5*. *Pd4* reflects a general feeling of “paranoid flavored resentments” (Caldwell, 1988). This subscale is the paranoid component of Scale 4, but with some depressive undertones. Nichols and Greene (1995) classified *Pd4* under their paranoid thought process category in their structural summary as it reflects severe alienation from others, and a sense of felt deprivation and of being given a “bum deal.” There is an element of residual sadness and longing in *Pd4* that indicates a vulnerable, lonely, and unhappy self. High *Pd4* scorers have a pervasive mistrust of others, who are viewed as more depriving than hostile. Consequently, they feel that others are uncaring and cannot be counted on (Nichols & Greene, 1995). Nichols (2011) states that *Pd4* is likely the most sensitive to severe childhood deprivation and neglect, and that high scorers have come to anticipate that others will withhold affection, support, encouragement, and similar forms of emotional nourishment. Lacking an adequate holding environment in childhood causes feelings of deprivation, and neglect/mistreatment by others with a sense of feeling that one’s needs have been ignored or devalued. This sense of emotional deprivation is supported by Wrobel’s (1992) findings that anchored clinician ratings to patient characteristics associated with elevated *Pd4* scores. Those characteristics included feeling socially isolated, a lack of gratification in social relationships, a lack of feeling of belongingness, and

externalizing blame. The finding of sadness from the Graham et al. (1999) study for male psychiatric outpatients is consistent with the lonely and unhappy individual just described. Levitt (1989) suggested examining *Pd1* when *Pd4* is elevated to ascertain if family members and intimates are the source of failed support. To this end, the clinician would want also to examine other measures, such as the *FAM* content scale. If only *Pd4* and *Pd5* (Self-Alienation) are elevated relative to the other *Pd* subscales, particularly *Pd2*, the individual may prove more likely to benefit from psychotherapy. However, research is needed to substantiate this conjecture (Lilienfeld, 1999).

Although *Pd4* and *Sc1* share identical scale titles, despite having only three items in common, the two subscales are importantly different. Nichols (2011) specified the major difference: “Whereas *Sc1* reflects a disinclination to form attachments to others, *Pd4* emphasizes an inability to do so, but with a sense of sorrow about this, unlike *Sc1*” (p. 124).

Low *Pd4* scorers feel understood, fairly treated, and enjoy a sense of belongingness in their social environments (Caldwell, 1988).

Self-Alienation (Pd5)

T-Scores > 65 are indicative of individuals who:

1. describe themselves as uncomfortable and unhappy
2. do not find daily life interesting or rewarding
3. verbalize regret, guilt, and remorse for past deeds, but are vague about the details
4. find it hard to settle down
5. may use alcohol excessively

T-Scores < 40 are indicative of individuals who:

1. present themselves as happy and comfortable
2. find daily life stimulating and rewarding
3. are willing to settle down
4. deny excessive use of alcohol
5. do not express regret, remorse, or guilt about past misdeeds

Pd5 (Self-Alienation—12 items): “Lack of self-integration; avowal of guilt, exhibitionistically stated; despondency (e.g., these items are often answered in the scored direction by alcoholics who refer themselves to treatment)” (Harris and Lingoes). *Pd5* is the depressive component of Scale 4. It overlaps *DEP* by 6 items ($r = .87$) and is also highly correlated with *PK* ($r = .88$) and *PS* ($r = .86$). The items tend toward a theme of self-reproach and ostentatious remorse. They have a neurotic flavor and appear distinctly out of place in a scale intended to model the psychopathy construct. Evidence exists (Voelker & Nichols, 1999) that this group of items does not contribute incrementally to the validity of Scale 4 when pitted against scores from the Psychopathy Checklist–Revised (PCL-R; Hare, 1991).

Pd5 appears to be an artifact of the effect of hospitalization on the criterion group cases. It may be one of the key elements in 2-4/4-2 code patterns, the so-called caught psychopath configurations. These reflect depressive phenomena that are largely inspired by situation, as a reaction to the felt need to enact mea culpa for tactical reasons, and to the inconvenience of having to live within a restrictive, style-cramping, institutional environment with its schedules, policies, rules, privilege levels, fixed menus, and so on. Among the standard clinical scales and subscales, *Pd5* is the most satisfactory measure of guilt.

Harris and Lingoes’ (1968) items for this subscale include feeling unhappy and misunderstood as well as dissatisfied with life. Ten of the items on *Pd5* are keyed True, two False. *Pd5* overlaps *DEP* by six items and is also highly correlated with *PK* and *PS*. Wrobel (1992) described feelings of despondency as a correlate of the high *Pd5* scorer, and Caldwell (1988) and Graham et al. (1999) described a similar feeling state underscoring the guilt and self-blame, regretful feelings, and feelings of hopelessness and unhappiness so typical of these individuals. The subscale appears sensitive to the anhedonia elements inherent in Scale 4 that McKinley and Hathaway (1944) viewed as an important component of the parent scale. Hence, *Pd5* appears to be the depressive component of Scale 4. However, it should be noted that the depressive item content of *Pd5* does not appear consonant with the conventional interpretation of a high 4 (*Pd*) score (Levitt, 1989). Typically, a high 4 scorer attributes his/her dissatisfaction to the environment rather than to oneself as is the case with an elevated *Pd5* subscale score. Reported by Levitt (1989), the depression items on *Pd5* help explain the high loadings on a depression factor for both sexes in the three patient populations tested by Foerstner (1986) in her factor analytic study of MMPI special scales. Nichols (2011) concurs that the items reflect a theme of self-reproach and appear distinctly out of place in a scale intended to represent the construct of psychopathy. Voelker and Nichols (1999) showed evidence that this group of items did not contribute incrementally to the validity of Scale 4 when compared against scores from the Psychopathy Checklist-Revised (PCL-R; Hare, 1991). Nichols (2011) sheds light on why these items appear on *Pd5* and on Scale 4. The reader will recall that many of the criterion group members for Scale 4 were hospitalized versus going to jail. *Pd5* appears to be an artifact of the effect of hospitalization on the criterion group cases. It may be one

of the key elements in 2-4/4-2 code patterns, the so-called caught psychopath configurations. These reflect depressive phenomena that are largely inspired by situation, as a reaction to the felt need to enact mea culpa for tactical reasons, and to the inconvenience of having to live within a restrictive, stylecramping, institutional environment with its schedules, policies, rules, privilege levels, fixed menus, and so on.

(Nichols, 2011, p. 125)

Nichols and Greene (1995, p. 29) believed that guilt, which can negatively affect one's capacity to enjoy life in a spontaneous and fluent fashion, is best assessed using *Pd5*. They pointed out that the level or intensity of guilt as measured by *Pd5* can be estimated from scores on *D5* (Brooding) and the *LSE* content scale. They elaborated by stating that it is important to discriminate guilt as a specific emotional state from states of more general upset in which guilt is only a component of distress and dysphoria. Many individuals experience guilt, regret, and remorse in the context of other, mostly unpleasant, emotions such as anxiety, fearfulness, apathy, depression, worry, and so forth. Such experiences often so obscure or obstruct the assessment of guilt per se that this emotional state and its role in the individual's psychic life are left uncertain. Guilt is most readily identified when *Pd5* and *D5* are elevated above *OBS*, as well as above the level of other distress scales such as *A*, *ANX*, *FRS*, *DEP*, *WRK*, and *TRT*.

The level or severity of the expressed guilt in high *Pd5* scorers approximates a theme of self-flagellation (with elevated *LSE*) with "exaggerated culpability and ostentatious remorse" (Nichols & Greene, 1995, p. 38). Caldwell (1988) and Nichols and Greene agreed that *Pd5* may also reflect the characteristic remorse seen in some alcoholic patterns (e.g. MMPI-2 code patterns 247/274, 427/472, and 724/742).

Low *Pd5* scorers do not report feeling unhappy, can in fact experience pleasures in life, find daily life stimulating and rewarding, do not express guilt or remorse about past misdeeds, and deny excessive use of alcohol (Graham, 1990).

Scale 4: Subtle-Obvious Subscales

Pd-O (Psychopathic Deviate-Obvious—28 items): Two-thirds of the *Pd-O* items overlap *Pd4* and *Pd5*, with the remaining one-third divided about equally between *Pd1* and *Pd2*. However, *Pd-O* is thematically dominated by *Pd5* and is predominantly distressed and depressive in tone. It is highly saturated with the First Factor (correlation with *A* = .84) and thus will be raised by any of the distress scales.

Pd-S (Psychopathic Deviate-Subtle—22 items): *Pd-S* is a more heterogeneous collection of items than *Pd-O* and is built around *Pd3*, its largest cluster of items at 6. It achieves its highest correlations with measures of extroversion (*Pd3* = .51, *Hy1* = .44; *SOD2* = -.37; *Si1* = -.35) but has no clear central theme. It correlates with *K* at .32. The items suggest an

individual who is inwardly conflicted although self-controlled, and outwardly socially insouciant, carefree, and imperturbable. Many items also assert independence and self-determination in the examinee's reactions and behavior. The overall effect is one of instability or brittleness, with a potential for stubbornness or argumentative overreaction to the assertions, demands, or complaints of others.

The Psychopathic Deviate-Obvious subscale (*Pd-O*) has 28 items, of which 20 are keyed True, 8 False; Psychopathic Deviate-Subtle (*Pd-S*) contains 22 items, of which 4 are keyed True, 18 False. The *Pd-O* items reflect various subjective discomforts that include feeling misunderstood, unhappy, and unfairly treated, and having gotten into trouble (Caldwell, 1988). Examining the convergent validity literature, Hollrah et al. (1995) concluded that methodological problems with the MMPI S-O studies make it difficult to summarize their validity as their research results reveal different findings for different scales. They reported, however, that in isolated studies, *Pd-O* does correlate with discomfort and the admission of social nonconformity. The content of *Pd-O* suggests feeling unhappy and at odds with others and with life. Low scores suggest a closeness and warmth with others and social conformity (Caldwell, 1988).

According to Nichols (2011, p. 125): Two thirds of the *Pd-O* items overlap *Pd4* and *Pd5*, with the remaining one third divided about equally between *Pd1* and *Pd2*. However, *Pd-O* is thematically dominated by *Pd5* and is predominantly distressed and depressive in tone. It is highly saturated with the First Factor (correlation with *A* = .84) and thus will be raised by any of the distress scales. Dahlstrom (1991) examined the correlates of the S-O subscales derived from partner ratings on the Katz Adjustment Scales used in the re-standardization. For both men and women, the following descriptions emerged as significant for high *Pd-O* scorers: lacks interest in things, feels others do not care about him or her, gets very sad or blue, has many fears, moody, worries about the future, takes nonprescription drugs, has been arrested or had legal difficulties, lacks social judgment, and whines and demands attention. For women only, the following represents a partial list of significant findings: poor sense of humor, restless, not affectionate, lacks energy, feelings easily hurt, easily annoyed, lacks self-confidence, lacks emotional control, argues about minor things, suspicious of others, has difficulty making decisions, and does not get along well with others. There were no unique descriptors for men.

Pd-S comprises a more mixed group of items than *Pd-O*, with an emphasis on *Pd3* (Social Imperturbability) given the items from the latter subscale. Although *Pd-S* correlates with measures of sociability/extroversions (*Pd3*, *Hy1*, and *Si1*), it does not appear to have a central theme. Nichols (2011, p. 125) describes the item content as follows: The items suggest an individual who is inwardly conflicted although self-controlled, and outwardly socially insouciant, carefree, and imperturbable. Many items also assert independence and self-determination in the examinee's reactions and behavior. The overall effect is one of instability or brittleness, with a potential for

stubbornness or argumentative overreaction to the assertions, demands, or complaints of others. Caldwell (1988) pointed out that some items on *Pd-S* appear nearly as obvious as the *Pd-O* items. These items report family quarrels, getting little sympathy, and wanting to leave home. The more subtle items are those reporting an absence of social anxieties, ease in talking to others, and a denial of manipulation. Dahlstrom (1991) derived the following correlates for *Pd-S* for men and women from the partner ratings made in the re-standardization sample: moody, stubborn, easily annoyed, swears or curses, not passive and obedient, talks too much, makes big plans, and has conflicts over sex. For men only, the following correlates were derived: trouble sleeping, not shy, lacks energy, gets very sad, and has been arrested or had legal troubles. For women only, the following correlates were derived: temper tantrums, resents being told what to do, argues about minor things, nags, feels others do not care about her, gets bossy, is uncooperative, lacks emotional control, and drinks excessively.

Low *Pd-S* scores suggest self-confidence, a sense of inner calmness, and a restraint or shyness with strangers (Caldwell, 1988). However, in reviewing the literature on the Subtle subscales, Hollrah et al. (1995) were unable to find studies that supported the discriminative validity of *Pd-S*. Therefore, appropriate caution is warranted.

05 – Mf – Masculine-Feminine



1) 50 items which were **intended as a measure of gender role development, including emotional reactions, interests, attitudes and feelings in which men and women differ**

a. did not make it

b. tends to measure androgyny, which also correlates with SES

c. *Examples (male): 74. I would like to be a florist. (T)*

103. I enjoy a race or a game more when I bet on it. (F)

d. *(female): 112. I like dramatics (T)*

120. I frequently find it necessary to stand up for what I think is right. (F)

2) scale constructed on men who sought psychiatric help to control their homoerotic feelings and to cope with problems of gender confusion

a. originally intended to be able to determine homosexuality (before it was thrown out as a diagnostic category)

1. doesn't work

3) No Harris-Lingoes

4) Not usually interpreted clinically

5) Still, for men:

a. **T-Scores > 65 (marked elevation) are indicative of men who:**

1. may have sexual problems and concerns

a) especially if their scores are markedly higher than expected for their intelligence, education, and social class

2. may be experiencing conflicts in sexual identity and insecurity about masculine adequacy

3. may display clear effeminate behaviors

4. may lack stereotypical male interests

5. have aesthetic and artistic interests

6. are likely to participate in housekeeping and childrearing activities to a greater extent than most men

7. may have a more androgynous orientation

i. especially among more educated men

8. are seen as intelligent, capable, valuing cognitive pursuits, ambitious, competitive, and persevering

9. are clever, clear-thinking, organized, and logical

10. show good judgment and common sense

11. are curious, creative, imaginative, and individualistic in their approach to problems

12. are sociable and sensitive to others

13. are empathic, tolerant, and capable of expressing warm feelings toward other people

14. often are seen as passive and dependent in relationships

15. seem to be peace-loving persons who make concessions and avoid unpleasant confrontations

16. show good self-control

17. are not likely to act out in delinquent ways

b. **T-Scores 58-64 (moderate elevation) are indicative of men who:**

1. tend toward aesthetic interests such as art, music and literature

2. are rather passive and prefer to work through problems in a covert and indirect manner

3. this is the typical range for most college-educated males

c. Normal range: **T-Scores 40-57**

d. **T-Scores < 40 (low scores) are indicative of men who:**

1. are presenting themselves as extremely masculine

2. have stereotypical masculine interests
3. overemphasize strength and physical prowess
4. are described by others as aggressive, thrill-seeking, adventurous, and reckless
5. may show coarse, crude, vulgar talk and behavior
6. may be compensating for basic doubts about their own masculinity
7. are seen by others as having limited intellectual ability
8. have a narrow range of interests
9. are inflexible and unoriginal in their approach to problems
10. prefer action to thought
11. are practical and nontheoretical
12. are not comfortable dealing with feelings and emotions

6) For women,

a. **T-Scores > 65 (marked elevation) are indicative of women who:**

1. are not interested in appearing or behaving according to traditional female roles
2. have interests that tend to be stereotypically more masculine than feminine
3. are active, vigorous, assertive, competitive, aggressive, and dominating
4. are seen by others as coarse, rough, and tough
5. are outgoing, uninhibited, and self-confident
6. are easygoing, relaxed, and balanced
7. are logical and calculated in their behavior
8. are unemotional
9. are seen as unfriendly by others
10. among hospitalized psychiatric patients, tend to be diagnosed as psychotic
11. it is unusual for women to score this high

b. **T-Scores 45-64 (normal and moderate elevation) are indicative of women who:**

1. are less traditionally oriented toward a feminine role
2. have an interest in both masculine and feminine activities

c. **T-Scores 35-44 (low scores) are indicative of women who:**

1. are genuinely interested in traditional feminine interests and activities
2. may be passive in their roles

d. **T-Scores < 34 (extremely low scores) are indicative of less educated women who:**

1. are presenting themselves as stereotypically feminine

2. are coy, seductive, and appear helpless
3. may be compensating for doubts about their own adequacy as women
4. tend to be passive, submissive and yielding
5. are described as constricted, sensitive, modest, and idealistic

e. T-Scores < 34 (extremely low) are indicative of more educated women who:

1. have a balanced view of gender role behavior
2. see themselves as capable, competent, and conscientious
3. are described by others as intelligent, capable, conscientious, forceful, considerate, easygoing, insightful, and unprejudiced

Men

T = >65 Lacks traditional masculine interests

T = 45---64 Interests similar to most men

T < 45 Traditional masculine interests (macho)

Women

T >65 Rejects traditional feminine role

T = 45---64 Interests similar to most women

T = <45 Traditional feminine interests; may be androgynous

>80 - serious sexual problem, in psychiatric patients: males - anxiety, depression, guilt; females - psychosis with hallucinations, delusions, suspiciousness

milder elevation - not traditional gender role (as indicated by vocational and aesthetic interests, sexual role interests, degree of dependency, and activity vs. passivity)

Low = traditional gender role

Scale 5: Masculinity-Femininity (MF)

The exact motivation of Hathaway and McKinley for developing Scale 5 could be somewhat unclear to readers consulting different texts, given the various accounts given to explain this scale's origins. For example, Dahlstrom et al. (1972, p. 201), generally considered the most reliable historical chroniclers of the MMPI, stated that Scale 5 was designed to identify the personality features related to the disorder of male sexual inversion Persons with this personality pattern often engage in homoerotic practices as part of their feminine emotional makeup; however, many of these men are too inhibited or full of conflict to make any overt expression of their

sexual preferences.

As Colligan et al. (1983) indicated, the 1943 MMPI *Manual* describes the *Mf* scale as intending to measure “the tendency toward masculinity or femininity of interest pattern in the direction of the opposite sex” (p. 40). Clearly, the original *Manual*’s description differs from the more psychopathological account given by Dahlstrom et al. (1972) in describing the origins and intent of Scale 5. Hathaway and McKinley discovered that it was too difficult in the early 1940s to obtain a large enough group of homosexual men and women possessing enough similar qualities to form suitable criterion groups (Hathaway, 1980). At least three subgroups of homosexuals were identified with different etiologies for their gender preference. One subgroup was a pseudohomosexual type with neurotic features related to inferiority; another subgroup was a psychopathic type who tended to elevate Scale 4 (*Pd*), and a third subgroup became the final reference criterion group. This group consisted of 13 homosexual men (Hathaway, 1980).

Although no demographic data were reported for these participants, they were screened for gross psychological abnormalities, like psychosis, clear-cut neurotic tendencies, and psychopathy. Their homosexuality was therefore considered to rest on a constitutional basis. These individuals were seen as having a feminine emotional makeup; however, many, not surprisingly given the times, were considered too inhibited or conflicted to express their homoerotic sexual preferences. Their feminine disposition was believed to be apparent in their expressive styles, interests, and attitudes, as well as in their sexual relationships (Dahlstrom et al., 1972). Greene (2011) stated that “such persons were thought to engage in homoerotic behavior as a part of their feminine (i.e. inverted) personality characteristics” (p. 125).

Many items used to develop *Mf* were added after the original Minnesota normative group had already participated in the construction of the other clinical scales; so newly formed normal groups were selected for comparison purposes. These groups consisted of 67 female airline employees and 54 soldiers. When an item differentiated a soldier from a member of the criterion group, the item was said to be a trend in the direction of femininity (Hathaway & McKinley, 1943). A second comparison step in item selection involved identifying a group of men scoring in the “feminine” direction on an “Invert” scale derived by Terman and Miles (1936). The item endorsements of these men were then compared with a group of normals. The use of the “Invert” scale from Terman and Miles’ (1936, as cited in Colligan et al., 1983) Attitude Interest Analysis Test “represents the first time that items from one diagnostic test were used to select a contrast group that was employed as an additional criterion group used for selecting items on an MMPI scale” (p. 44). A third comparison step, which appears to have been conducted initially but is considered the least important by Hathaway (1980), involved comparing the normal men (soldiers) with normal women (airline employees) to determine their response frequencies by gender.

The 60 items that survived all three comparison steps became Scale 5. Twenty-three of the Scale 5 items are borrowed from Terman and Miles (1936), whereas the other 37 items came from the MMPI item pool.

Despite some preliminary efforts, Hathaway and McKinley were unable to successfully construct an independent scale measuring female homosexual inversion. A number of subsequent studies have demonstrated that despite the efforts of the scale constructors, Scale 5 does not adequately discriminate male homosexuals from non-homosexual males, contrary to the original intent of the scale (Wong, 1984). It is therefore important

not to infer homosexuality based solely on an elevated *Mf* score. In fact, it is difficult to predict homosexuality from MMPI or MMPI-2/RF data. At present, an individual's sexual orientation can generally be learned by simply asking about it, whereas this was more difficult to do when Hathaway and McKinley constructed the MMPI. The final *Mf* scale was believed to measure masculinity at one pole and femininity at the opposite pole; therefore, the scale was seen as being bipolar. However, as other researchers (e.g. Bem, 1974; Constantinople, 1973) suggested, masculinity and femininity may be more accurately assessed using separate scales for each dimension. Each may represent a different construct. On the other hand, Bem's measures of gender role are not independent of masculinity versus femininity scales, such as *Mf* (Wakefield, Sasek, Friedman, & Bowden, 1976). Also, the psychometric adequacy of Bem's Femininity scale has been criticized (Kimlicka, Wakefield, & Friedman, 1980; Kimlicka, Wakefield, & Goad, 1982). Other studies (e.g. Kimlicka, Sheppard, Wakefield, & Cross, 1987) suggest that bipolar masculinity-femininity scales have not yet been, and may not be, replaceable with separate masculine and feminine factors. However, the *Manual* (Butcher et al., 2001) describes two gender-role scales developed by Peterson and Dahlstrom (1992). These scales, Gender Role—Masculine (*GM*) and Gender Role—Feminine (*GF*), were designed as independent measures of the masculine and feminine dimensions in Scale 5. Developed on data provided by the normative sample for the MMPI-2, these scales can be useful adjuncts to aid in the interpretation of Scale 5. The *Manual* (Butcher et al., 2001) provides the psychometric data for these scales.

Because Scale 5 (and 0) were added after the initial publication of the MMPI, it took time for its assimilation into the mainstream of research and clinical practice. It was soon recognized that Scale 5 was an important measure, and research attention was eventually paid to the scale, although Harris and Lingo (1955) and Wiener and Harmon (1946) did not develop subscales for Scale 5 (or Scale 0).

Factor analytic studies of Scale 5 indicate that the scale is not bipolar but comprises multiple factors (Graham, Schroeder, & Lilly, 1971; Sines, 1977). Graham et al. (1971) factor analyzed the responses from 422 psychiatric inpatients, outpatients, and normals, and found six factors. Serkownek (1975) later used these findings as a basis for his development of *Mf* subscales to assist in the interpretation of Scale 5: Narcissism-Hypersensitivity (*Mf1*), Stereotypic Feminine Interest (*Mf2*), Denial of Stereotypic Masculine Interests (*Mf3*), Heterosexual Discomfort-Passivity (*Mf4*), Introspective-Critical (*Mf5*), and Socially Retiring (*Mf6*). *Mf2*, *Mf4*, and *Mf5* lost only two, one, and one items, respectively, in the re-standardization. Although the Serkownek subscales remain largely intact, these have now been superseded by those of Martin and Finn (2010), described below.

Given its multidimensional character, inferences about masculinity and femininity drawn from *Mf* elevations should be made cautiously. Nonetheless, regardless of the heterogeneity of its content, *Mf* does seem to a degree to reflect, among other things, stereotypic masculine and feminine interest patterns. Items reflecting masculine-feminine interests appear to have the highest correlation with overall scale scores and are therefore considered the most differentiating items on the scale (Dahlstrom et al., 1972). Although the interest-type items are obvious or face valid, other items on the scale carry more subtle meaning. According to Nichols (2011, p. 137), Scale 5's ...

Raw scores are normally distributed and it appears to function primarily as a measure of an individual difference variable. Scale 5 can make an important contribution to

clinical descriptions, particularly in the way it may modify descriptions based on the other clinical scales and to issues related to treatment.

The *Mf* items are approximately evenly distributed between (1) sex role-related interests, activities, and vocations, and (2) an admixture of items comprised of apprehension, sexual worries, sensitivity, social reserve, and denial of cynicism and mistrust. Nichols (2011) suggested conceptualizing Scale 5 as a “family of dimensions” related to the broader construct of activity–passivity. He describes the active pole (low males, high females) as reflecting different traits, including dominance, competition, exhibitionism, intrusiveness, and acting out; whereas the passive pole (high males, low females) includes traits such as submission, dependency, cooperation, artistic, tender, verbal, and valuing nurturance, relatedness, mutuality, and style/appearance. According to Nichols (2011, p. 139):

For both sexes, low scores tend to reflect a narrow interest pattern that may be overly tied to sex-role constraints, expectations, and identifications. High scores suggest a broader, more inclusive range of interests, which, at the extreme, may reflect identity diffusion or may become chaotic. In schizophrenia, the identity disturbance may involve a sense of uncertainty such that the boundary between what are and are not one’s interests becomes highly permeable. In mania, the identity disturbance involves expanding the experience of the self to encompass an unrealistically overinclusive endorsement of interests.

Scale 5 lost four items in the MMPI-2 revision, leaving it with 56 items. The four dropped items (items 69, 70, 249, and 295) were either outdated or often considered offensive on a religious or sexual basis. Fifty-two of the items on *Mf* are keyed in the same direction for men and women. An endorsement of any of these items in the keyed direction gives the respondent a point in the direction of femininity. Four of the items deal with clear sexual concerns and represent a scoring exception in that they are keyed in the opposite direction for women and men. Because of the obvious nature of these four *Mf* items, one wishing to conceal his or her sexual interests can easily do so.

In hand scoring, it is important to use the appropriate male or female template for scoring the answer sheet. For men, 25 items on *Mf* are keyed True, 31 keyed False. For women, 23 items are keyed True, 33 False. Because there is a fairly even balance between True and False keyed responses, an All-True or All-False response set will not significantly elevate scale scores. Greene (2011, p. 126) further expands on the scale’s psychometric properties by stating:

There are 33 (58.9%) items unique to Scale 5 (masculinity-femininity [MF], which is the largest percentage of unique items for any of the clinical scales. It shares no more than 4 items with any clinical scale other than Scale 0 (Social Introversion [Si] with which it shares 9 items.

Scale 5 also shares one, two, and three items with the *L*, *F*, and *K* scales, respectively, and shares the most items with Scale 0 (nine items). “With the exception of *Gf* (.70) and *Gm* (–.52), Scale 5 is only weakly correlated with most other MMPI-2 scales” (Nichols, 2011, p. 135).

Scale 5 uses linear *T*-scores rather than uniform *T*-score conversions. This is also the case for Scale 0 and the *L*, *F*, and *K* scales. For women, high *T*-scores on the profile sheet are associated with low raw scores, indicating a response to the items in a “masculine” direction. For men, the converse is true, with high raw scores associated with high *T*-scores. Therefore, a man with a high raw score or high *T*-score is said to be endorsing Scale 5 items the way in which women stereotypically respond. Low *T*-scores in men

reflect a low endorsement of feminine-type items and indicates a more masculine interest pattern. The reason for reversing the raw scores on the profile sheet is to maintain uniformity with the other scales, in that high scores represent a form of deviation. In the case of Scale 5, elevated T -scores represent endorsement patterns similar to the opposite gender.

In Hunsley et al.'s (1988) large-scale meta-analysis of MMPI reliability studies using a wide variety of populations conducted between 1970 and 1981, an average internal consistency of .73 across 39 studies was reported. They also reported an average test-retest reliability of .69 for 10 studies, with time intervals from one day to two years. The *Manual* (Butcher et al., 2001) reports Mf reliability data for a subset of the normative sample (82 men and 111 women). An average interval of about one week shows Mf to have a test-retest correlation of .82 and .74 for men and women, respectively. Internal consistency estimates (coefficient alpha) for men and women were .58 and .37, respectively.

Mf is one of the scales most affected by the revision of the MMPI. It appears that men in the re-standardization group answered more items in the "feminine" direction, as compared with the original fixed reference group. This has resulted in the lowering of most men's T scores on Mf by about 10 T -scores (Dahlstrom & Tellegen, 1993; Duckworth & Anderson, 1995; Friedman, 1990; Strassberg, 1991). For women, there is much less change in the endorsement frequencies of the items and women's T -scores are less dramatically affected. Another factor that influences elevations on Scale 5 is education level. In the re-standardization sample, less educated men earned lower T -score means on Scale 5 and less educated women obtained higher average T -score values. Compared to the original MMPI normals, the re-standardization normals were better educated, so that scores on Scale 5 are about 10 T -scores lower in men and 2–3 T -scores higher in women. Greene (2011) suggests that more research is needed to determine if the older correlates for the MMPI Scale 5 are applicable to the MMPI-2.

Moderator scales affecting the interpretation of Scale 5 elevations include Ss (Social Status; Nelson, 1952) and Es (Ego Strength; Barron, 1953). High scores on these scales both tend to emphasize the positive aspects of Mf scores, regardless of whether the latter are high or low. Scale 4 (Pa) is also an important moderator of Scale 5 scores. Nichols (2011, p. 135) provides a description for interpreting Scales 4 and 5 in a configural fashion:

Scores on Scale 4 strongly influence the interpersonal aspects of high Scale 5 raw scores. For men, the strength of the patient's basic attachment to others, his commitment to the maintenance and repair of close relationships, and his capacity for trust, optimism, warmth, and forgiveness are indicated by the extent to which Scale 5 exceeds Scale 4, provided that 4 does not exceed T -55. For women, the same pattern of positive trends is given by the extent to which Scale 4 exceeds Scale 5, provided that 4 does not exceed T -60. As Scale 4 is elevated beyond these limits, especially as it exceeds Scale 5 for men, there tend to be chronic problems in the quality, strength, and stability of attachments. Such patterns tend to predict passiveaggressive struggles; significant conflicts around dependency-independency; a tendency to react to requests as if they were demands; and a quickness to feel dominated (especially with men feeling dominated by women) and to reflexively rebel against this feeling. With high scores on Scale 3, elevations on Scale 4 are more benign than otherwise. Scale 5 tends to focus the rebelliousness and authority

conflict that accompany Scale 4 and give them an intellectual/philosophical basis, such that many men with this pattern are better described as anti-authoritarian rather than anti-authority.

Investigations of the correlates for high and low *Mf* scores in normals have been conducted by Hathaway and Meehl (1952, as cited in Dahlstrom et al., 1972) and Gough, McKee, and Yandell (1955). Hathaway and Meehl found that high *Mf* normal men were described by their peers as sensitive and prone to worry, idealistic and peaceable, sociable and curious, and having general aesthetic interests. Women with high *Mf* scores did not have correspondingly similar descriptors, but were described as adventurous. Low-scoring men were described by their peers as practical, balanced, cheerful, selfconfident, and independent, whereas low-scoring women were seen as sensitive, responsive, modest, grateful, and wise.

Gough et al. (1955) described the high Scale 5 man as inner-directed and intellectually curious. Work and achievements provided these men significant gratification, and they were seen as mature, self-aware individuals. They had good judgment and common sense. They could communicate effectively and were quite verbal. Some of the adjectives typical of these high Scale 5 men included ambitious, clear-thinking, effeminate, imaginative, nervous, organized, sensitive, and submissive. Low-scoring men were seen as lacking insight into their motives, preferring action to thought, and having narrow interests. They did not appear to have the psychological complexity or inner-directedness that the high Scale 5 men had. Nichols and Greene (1995) provided a good summary of high *Mf* scores in men (low scores in women). They stated that the *Mf* scale emphasizes passivity, sensitivity, and aesthetic and/or intellectual interests: "Sedentary activities and pastimes are preferred over those involving movement, competition, and the out-of-doors. *Mf* seems to reflect intellectualization over rationalization" (Nichols & Greene, 1995, p. 35). Long and Graham (1991), using ratings provided by significant others, studied the descriptions of normal men with various score levels of Scale 5. The participants were 819 heterosexual couples who were included in the normative samples for the MMPI-2 (Butcher et al., 1989). In contrast to previous literature indicating high Scale 5 men to be passive, dependent, and submissive, they found that men with higher Scale 5 scores actually tended to be less passive and obedient. They found that level of education was a better predictor of certain behaviors and personality characteristics than *Mf* scores in normal men.

The correlates for high and low *Mf* scale scores vary as a function of the type of individuals being assessed. For example, high Scale 5 scores are frequently obtained by normal married men, although not for women (Dahlstrom et al., 1972). Although relatively frequent among normal men, Scale 5 is not often a high point among psychiatric patients (Tanner, 1990). Given that much of the *Mf* item content suggests mild maladjustment, Ward and Dillon (1990) investigated whether emotional distress is a correlate of the *Mf* scale in clinical populations. In studying the *Mf* raw scores and symptom ratings obtained on psychiatric patients, emotional distress correlates for Scale 5 were identified. Anxiety, depressed mood, guilt feelings, and tension were associated with high ("feminine") raw scores in both men and women. It is interesting to note that Ward and Dillon found these correlates to be largely independent of other MMPI clinical scales.

It is clear that high Scale 5 scorers, particularly men, vary in their behavioral descriptions or diagnoses as a function of their normal versus psychiatric status. High

Mf scores in men (low *Mf* scores in women) in the normal population may indicate sensitivity, as well as aesthetic or intellectual interests, particularly if the person is college educated. Traditionally, the literature has emphasized the passivity or submissiveness often noted in high Scale 5 men, although Long and Graham (1991) found opposite trends. An underlying dimension of Scale 5 has been hypothesized to be role flexibility (Kunce & Anderson, 1976, 1984). The high Scale 5 man is able to appreciate a diversity of interests and show tolerance for differences in others. Traditional masculine interests are likely to be expressed by men who score in the *T*-46–55 range. Scores below 46 begin to suggest a more “macho” orientation, with very low scores (*T* < 40) strongly suggestive of an activity-oriented, nonverbally expressive type of individual who may be perceived as insensitive, competitive, aggressive, independent, and possibly crude, with traditional masculine–feminine views and possible underlying doubts about his own masculinity. High Scale 5 women are likely to be seen in many ways similar to low Scale 5 men, that is, as aggressive, competitive, dominating, energetic, and confident. The low Scale 5 woman may be described as hyperfeminine if her score is below a *T*-score of 40 and if she is not college educated (Graham, 1990). Between *T*-scores of 40 and 55, she is likely to be described as having stereotypically feminine interests. Clearly, high and low *Mf* scores vary greatly in their correlates for men and women. The reader interested in more detailed descriptions of diagnostic feedback and treatment considerations is referred to Nichols (2011) and Levak et al. (2011). Overall, one’s symptomatic pattern, presenting problem, interpersonal relations, history, and diagnostic considerations are strongly dependent upon the relation of *Mf* with other Scales.

Martin-Finn Subscales

A new set of seven *Mf* subscales has been developed for the MMPI-2 by Martin and Finn (Martin, 1993; Martin & Finn, 2010) using factor analytic procedures. The normative sample used in constructing these subscales was the MMPI-2 community participants (Butcher et al., 1989). These subscales are free of item overlap and have internal consistency coefficients high enough to suggest that they are cohesive measures. The first subscale, Denial of Stereotypical Masculine Interests, is a measure of lack of interest in activities typically considered male or masculine. The second subscale, Hypersensitivity-Anxiety, is a measure of self-focused worry and sensitivity. Stereotypical Feminine Interests is the third subscale and is a measure of activities typically considered female or feminine. Low Cynicism, the fourth subscale, is a measure of the lack of cynicism and suspiciousness about human motivations. Aesthetic Interest is the fifth subscale and is a measure of interest in the arts and written expression. The sixth subscale, Feminine Gender Identity, measures the wish to be female and to have interests traditionally associated with women. Restraint is the seventh subscale and is a measure of restraint from loud and aggressive interests and behaviors. Martin and Finn also provided a composite bipolar femininity–masculinity scale that is a combination of the three subscales that they believe to be the most central to the construct of masculinity–femininity (E. H. Martin, personal communication, April 8, 1996). These subscales are: Denial of Stereotypical Masculine Interests, Stereotypical Feminine Interests, and Feminine Gender Identity. Table A.2 in Appendix A (pp. 546–547) of Friedman et al. (2001) provides the item composition for these subscales, the scoring direction for the items, and the means and standard

deviations for the MMPI-2 normative sample. Table B.7 in Appendix B (pp. 546–547) of Friedman et al. (2001) provides the linear *T*-score conversions for these subscales.

06 – Pa – *Paranoia*



1) 40 items which reflect both marked interpersonal sensitivities and a tendency to misinterpret the motives and intentions of others

a. *Examples: 361. Someone has been trying to influence my mind. (T)*

286. Most people inwardly dislike putting themselves out to help other people. (F)

2) scale developed on patients showing primarily some form of paranoid condition or paranoid state

3) Harris-Lingoes Scales

a. persecutory ideas

b. poignancy

1. susceptible to strong negative emotions

c. naivete

4) **T-Scores > 70 (extreme elevation) are indicative of individuals who:**

a. may exhibit frankly psychotic behavior

b. have disturbed thinking, delusions of persecution or grandeur, and ideas of reference

c. feel mistreated and picked on

d. feel angry and resentful

e. harbor grudges

f. utilize projection as a defense mechanism

g. often receive diagnoses of schizophrenia or paranoid disorder

5) **T-Scores from 60-70 (marked elevation) are indicative of individuals who:**

a. have a paranoid predisposition

b. tend to be excessively sensitive and overly responsive to others' opinions

c. feel they are getting a raw deal out of life

d. tend to rationalize and blame others for their problems

- e. are suspicious and guarded
- f. display hostility, resentment, and an argumentative manner
- g. are moralistic and rigid in opinions and attitudes
- h. overemphasize rationality
- i. if female, may describe sadness, withdrawal, and anxiety
- j. if female, are seen by others as emotionally labile and moody
- k. have a poor prognosis for therapy
- l. rationalize excessively in therapy
- m. in therapy, reveal hostility and resentment toward family members

6) T-Scores from 50-60 (moderate elevation) are indicative of individuals who:

- a. have a paranoid orientation toward life
- b. see the environment as demanding and not supportive
- c. are very sensitive to what other people think of them
- d. are suspicious of the motives of others
- e. commonly feel angry and resentful

7) T-Scores between 35-50 (normal range) are indicative of normal individuals who:

- a. are socially interested
- b. face life's situations adequately
- c. are seen as balanced, orderly, and reasonable
- d. tend to be cautious, conventional, and self-controlled

8) T-Scores between 35-45 (normal range) are indicative of individuals in a clinical population who:

- a. are seen as stubborn, evasive, and guarded
- b. are likely to be self-centered, overly sensitive, and dissatisfied
- c. have narrow interests
- d. approach problems in flexible ways

9) T-Scores < 35 (low scores) are indicative of individuals who:

- a. have narrow interests
- b. tend to be insensitive to and unaware of the motives of other people
- c. tend to be evasive, defensive, and guarded
- d. may be shy, secretive, and withdrawn

T > 75 Psychotic symptoms, including delusions of persecution and ideas of reference

T = 65---74 Paranoid style, guarded, extremely sensitive to opinions of others; may feel mistreated; blames others; suspicious, resentful, withdrawn; hostile and argumentative

T = 55---64 Overly sensitive; guarded, distrustful ,angry, resentful

T = 45---54 Average score; no interpretation

T < 45 Low score; no interpretation

Harris---Lingoes

Pa1 – Persecutory Ideas

Pa2 – Poignancy

Pa3 –Naiveté

>75 - psychosis, paranoia, paranoid schizophrenia with delusions of persecution moderate elevation - hostile, externalizing, hypervigilant/suspicious, egocentric, self-righteous, angry, sexual deviation or preoccupation is probable

Pa1 - Persecutory ideas - perceive others as threat, feel misunderstood, blame others, project conflicts and responsibility

Pa2 - Poignancy - perceive self as more sensitive and intense in feelings than others, feel misunderstood/lonely, may be stimulation/risk-seeking

Pa3 - Naivete - trusting, deny hostility and ulterior motives in self and others

<40 - underachievers, interpersonally insensitive, optimistic; in psychiatric pt-s - subtle defensiveness, suspicion, controlled anger, paranoid disorder (in bright pt-s)

Persecutory Ideas (Pa1)

T-Scores > 65 are indicative of individuals who:

1. view the world as a threatening place
2. feel misunderstood and unfairly treated
3. feel that others have unfairly blamed or punished them
4. are suspicious and untrusting of others
5. in extreme cases, have delusions of persecution

T-Scores < 40 are indicative of individuals who:

1. feel understood and fairly treated
2. are able to trust others
3. do not project blame for problems and shortcomings

Pa1 (Ideas of External Influence—17 items): “Externalization of blame for one’s problems, frustrations, failures; in the extreme degree, persecutory ideas; projection of responsibility for negative feelings” (Harris & Lingoes). 8 items overlap *F* and 8; 6 items overlap *Pd4*. *Pa1* contains 4 related and somewhat overlapping subsets of items: (1) *Resentment* (items 17, 22, 42, 145, and 234). These items reflect fixed ideas of mistreatment and victimization; some have a secondary depressive theme (e.g., 22 and 234). (2) *Ideas of Reference* (items 259, 305, and 333). (3) *Delusions of Control* (items 24, 144, 162, 336, 355, and 361). This set reflects ideas (delusions) that one’s will and mind are being weakened, undermined, or subverted (e.g., by hypnosis or poisoning). (4) *Persecutory Ideas/Delusions* (items 42, 99, 138, 144, 259, 333, and 314F). The *Pa1* items express the idea that one is an object of interest to hostile forces. Unless *T*-scores on *Pa1* are equal to or greater than *T*-100, it is possible that the patient endorsed items on one or two of these subgroups without having endorsed any items on the others. The implications for psychosis vary from modest in the first and second subgroups, to intermediate in the fourth, and strong in the third. The second and fourth subgroups are sensitive to actual (as distinct from delusional) plotting and persecution. For example, persons awaiting trial may respond to some of these items with reference to the prosecuting attorney as the latter builds a case and plots strategy to try to ensure a verdict of guilty and punishment for the defendant. High *Pa1* scorers report feeling beset by hostile forces. These forces are generally experienced as implacable and far more powerful than the subject. Implicit in *Pa1* is the disposition to projection and the externalization of blame.

The four *Pa1* themes noted above are represented in scales more fully described in Nichols and Crowhurst (2006) and in Appendix. These are *Resentment (Pf1)*, *Ideas of Reference (Pf2)*, *Delusions of Control (Pf3)*, and *Ideas/Delusions of Persecution (Pf4)*.

Pa1: Persecutory Ideas (17 Items)

Sixteen of the 17 items on *Pa1* are keyed True and mostly reflect the persecutory content of Scale 6. Harris and Lingoes (1968) described the content of this subscale as consisting of “Externalization of blame for one’s problems, frustrations, failures; in the extreme degree, persecutory ideas; and projection of responsibility for negative feelings.” Nichols and Crowhurst (2006) described four related and somewhat overlapping subsets of items that permit a useful breakdown of *Pa1* scores: (1) *Pf1*: Resentment (items 17, 22, 42, 145, 234, and 484), reflecting fixed ideas of mistreatment and victimization with some items having a secondary depressive theme; (2) *Pf2*: Ideas of Reference (items 251, 259, 305, 333, 424, and 549); (3) *Pf3*: Delusions of Control (items 24, 144, 162, 216, 228, 336, 355, and 361), delusional items suggest that one’s will and mentation are being influenced (e.g. weakened; subverted by external forces); and (4) *Pf4*: Persecutory Ideas/Delusions (items 42, 99, 138, 144, 216, 259, 333, and 314). Nichols (2011) points out that unless *Pa1* scores equal or exceed *T*-100, it is possible that the test taker may have endorsed items on only one or two of these subgroups. This suggests that a careful inspection of the endorsed *Pa1* items be conducted, as such endorsements may realistically reflect that one may actually be followed by an angry spouse’s private investigator, or a claims adjustor trying to build a case against a person, the aims of a prosecuting attorney, and so on. On the other hand, item endorsements reflecting ideas of reference or delusions of control are likely to indicate a psychotic process.

Ward, Kersh, and Waxmonsky (1998) suggested that *Pa1* is the only MMPI-2 scale or subscale that measures uniquely paranoid ideas. These researchers derived a threefactor structure for the Scale 6 using substance abuse patients, and found that *Pa1* and the Paranoid factor had 14 of 16 items in common, thereby supporting the construct validity of this subscale. It should be noted that although *Pa1* substantially overlaps *PSYC* (eight items, 32 percent of *PSYC*) and *BIZ* (seven items, 30 percent of *BIZ*), the latter two scales intermix explicitly paranoid items with non-paranoid psychotic symptoms. Wrobel (1992) found projection to be a defense associated with patients having high *PA1* scores. Nichols and Greene (1995) stated that their paranoid thought process category is best represented by *Pa1* “which emphasizes persecutory ideas, resentment, and convictions of having been unfairly treated, and delusional ideas of being attacked, influenced, subverted, or undermined” (p. 32). They also noted that *Pa-0* is highly redundant with *Pa1*. High *Pa1*

scorers tend to feel that the world is an unsafe or hostile place and that others are not to be trusted. “The *Pa1* items express the idea that one is the object of interest to hostile forces” (Nichols, 2011, p. 147). These forces are experienced as far more powerful than the subject. It is not surprising that *Pa1* and *Pd4* (Social Alienation) share six items in common and are highly intercorrelated in a sample of psychiatric inpatients and outpatients (Nichols & Greene, 1995). High scorers tend to blame others for their problems, feel that others have unfairly blamed or punished them, and feel misunderstood (Graham, 1990). It is not surprising to learn that high male *Pa1* scorers in the Graham et al. (1999) investigation of psychiatric outpatients tended to report a history of being physically abused as well as reporting a history of committing domestic violence, a finding generally supportive of the clinical lore and empirical data linking the two.

Low scorers do not endorse items suggesting externalization of their problems or the use of projection as their main mechanism of defense, and tend not to externalize their problems. However, Caldwell (1988) stated that raw scores as low as five or six may point to a paranoid process.

Poignancy (*Pa2*)

T-Scores > 65 are indicative of individuals who:

1. see themselves as more high strung and more sensitive than others
2. say they feel more intensely than others
3. feel lonely and misunderstood
4. look for risky and/or exciting activities to make themselves feel better

T-Scores < 40 are indicative of individuals who:

1. feel accepted and understood
2. do not present themselves as more sensitive than others
3. avoid risky or dangerous activities

Pa2 (Poignancy—9 items): “Thinking of oneself as something special and different from other people; high-strung; cherishing of sensitive feelings; overly subjective; thin-skinned (Harris & Lingo). *Pa2* is the depressive

component of Scale 6. The items connote extraordinary emotional sensitivity or vulnerability that is dysphoric in tone. These items have a “poor little me” flavor, portraying the self as meek and innocuous, emotionally fragile, incapable of being a threat to others, and perhaps as being entitled to special concern and consideration for one’s tender sensibilities. There is an implicit theme of resentment and a lack of forgiveness (“for the way you hurt me”), however, and high scorers nurse grudges and are viewed as injustice collectors.

Pa2: Poignancy (9 Items)

This subscale appears to measure how sensitive or thin-skinned an individual is in reaction to others. Seven of the items are keyed True, two False. An All-True response set will therefore elevate *Pa1*. Harris and Lingo (1968) provided the following content descriptors for *Pa2*: “Thinking of oneself as something special and different from other people; high-strung; cherishing of sensitive feelings; overly subjective; and thin-skinned.” This subscale reflects a facet of the mood or feeling aspect of depression (Nichols & Greene, 1995). In fact, Nichols (2011) refers to *Pa2* as the depressive component of Scale 6, as the scale items connote extraordinary dysphoric vulnerability. Individuals with high scores report an unusual intensity of feelings, angry resentment, a painful sensitivity to criticism, cry easily, feel misunderstood, and feel lonely even in the presence of others (Caldwell, 1988; Graham et al., 1999). These individuals tend to see themselves as taking a longer time to heal from emotional hurts as compared to others, and recognize that they are easily wounded (Levitt, 1989). It appears that high scorers are grievance collectors who nurse grudges fueled by resentment and an inability to forgive others, most likely including empathic failures. Feeling more high-strung than others, high scorers may also tend to look for risky or exciting activities to make them feel better (Graham, 1990). Low scorers feel understood and accepted and do not experience themselves as more sensitive than others (Caldwell, 1988; Graham, 1990).

Naiveté’ (Pa3)

T-Scores > 65 are indicative of individuals who:

1. express extremely naive and optimistic attitudes about others

2. see others as honest, unselfish, generous, and altruistic
3. present themselves as trusting
4. say they have high moral standards
5. deny hostile and negative impulses

T-Scores < 40 are indicative of persons who:

1. have rather negative and suspicious attitudes towards other people
2. see others as dishonest, selfish, and untrustworthy
3. admit to some hostility/resentment toward others who make demands on or take advantage of them

Pa3 (Moral Virtue [formerly Naivete]—9 items): “Affirmation of moral virtue, excessive generosity about the motives of others; righteousness about ethical matters; obtuse naivete; denial of distrust and hostility” (Harris & Lingo). Similar to *Hy2* (shares 3 items and the theme of denied cynicism), *Pa3* is nevertheless distinctive. Whereas 9 of the 12 *Hy2* items make explicit reference to the self (“I”), only 5 of the 9 *Pa3* items do so. For most of the *Pa3* items, the focus is on others (“Most people”) rather than the self. (The same theme pervades the 7 items on *CYN* [6 on *CYN1*], with which *Pa3* is negatively overlapping; $Pa3 \cdot CYN = -.83$.) Thus, whereas *Hy2* denies negative dispositions in the self, *Pa3* denies such traits in others. *Pa3* also denies normal paranoia about the level of selfishness, expediency, and dishonesty that one may reasonably, however regrettably, expect to encounter in the social environment. Notwithstanding their denial of paranoid attitudes, high scorers tend to be viewed as hostile and as manifesting paranoid ideation (Graham et al., 1999). *Pa3* is independent of scores on Scale 6 ($-.02$) but moderately negatively correlated with *Pa1* ($-.44$) and pushed up by *K* ($r = .64$).

Pa3: Naivete (9 Items)

Harris and Lingo (1968) provided the following content descriptors for *Pa3*: “Affirmation of moral virtue, excessive generosity about the motives of others; righteousness about ethical matters; obtuse naivete; and denial of distrust and hostility.” Thus this subscale

primarily measures how one perceives other people in terms of their trustworthiness. Eight of the nine items are keyed False, making *Pa3* susceptible to the effects of an All-False response set. High scorers tend to have optimistic and naive attitudes about others and themselves and may have difficulty experiencing forgiveness when they feel they have been deceived or treated unfairly (Butcher et al., 2001; Caldwell, 1988; Graham, 1990). There appears to be an underlying rigidity of opinions and attitudes that translates into a judgmental orientation toward others' behavior (e.g. good/bad, right/wrong, and moral/immoral). For this reason, Caldwell (1988) thought that *Pa3* would be better named Moral Righteousness. High scorers endorse items reflecting benign to positive expectations regarding the honesty and trustworthiness of others, denying cynical attitudes. Meehl and Hathaway (1946, as cited in Ward et al., 1998) speculated that "paranoid deviates are characterized by a tendency to give two sorts of responses, one of which is obviously paranoid, the other 'obviously' not" (p. 293). *Pa3* (and *Hy1*) are negatively correlated with *CYN* (both at $-.83$; Greene, 2011), and seven *Pa3* items negatively overlap *CYM*.

In outpatient mental health settings, high *Pa3* scorers tend to be viewed as hostile and as manifesting paranoid ideation despite their denial of paranoid attitudes (Graham et al., 1999). Low scorers view others as untrustworthy and motivated by self-interest, and are likely to be suspicious of their motives. Nichols and Greene (1995) suggested that a low *Pa3* score coupled with a high *Hy2* (Need for Affection) score reflects cynicism of a competitive, narcissistic, or suspicious variety.

Scale 6: Subtle-Obvious Subscales

Pa-O (Paranoia-Obvious—23 items): More than three-quarters of the *Pa1* items are contained in *Pa-O*—making up more than half of the latter's items, with an additional 5 items coming from *Pa2*. None overlap with *Pa3*. It is thematically dominated by *Pa1* and is largely redundant with it ($r = .93$). *Pa-O* may be thought of as the psychotic component of Scale 6; it is highly correlated with *PSYC* (.86), Scale 8 (.85), and *BIZ* (.82), but also contains a subtheme of vulnerability.

Pa-S (Paranoia–Subtle—17 items): All of the *Pa3* items are contained in *Pa-S* and dominate its content ($r = .79$); 4 of the remaining items overlap *Pa2*. It is most highly correlated with measures of cynicism ($CYN1 = -.61$, $ASP1 = -.59$, $CYN = -.56$, $ASP = -.53$) and is essentially independent of *Pa-O* ($r = -.09$) and *Pa2* ($r = .00$). It correlates with *K* at .32.

The Paranoia–Obvious subscale (*Pa-O*) has 23 items, of which 20 are keyed True, 3 False; 15 items overlap *Pa1*. Not surprisingly, Nichols and Greene (1995) reported a high correlation ($r = .94$) between *Pa1* and *Pa-O* in a sample of psychiatric inpatients and outpatients. Paranoia-Subtle (*Pa-S*) has 17 items, of which 5 are keyed True, 12 False. *Pa-O* appears to be the psychotic component of Scale 6 as it is highly correlated with Scale 8, *PSYC*, and *BIZ*. Caldwell (1988) placed the 23 *Pa-O* items into three categories: (a) persecutory paranoid items (e.g. feeling personally mistreated and knowing who your enemies are), (b) feelings of loneliness and social isolation, and (c) self-awareness of a distressingly low threshold for emotional reactions (e.g. hypersensitivity). Overall, *Pa-O* appears to emphasize the operation of blaming and attributing hostility to others, as well as including a few oversensitive/depressive items from *Pa2*. Hollrah et al. (1995) reviewed Wrobel and Lachar's (1982) results and reported that *Pa-O* correlated positively with measures of discomfort and reality distortion. Dahlstrom et al. (1972) reported that Wiener and Harmon (1946) found that the original Minnesota normal men endorsed the *Pa-O* items much less frequently than they did those of the other obvious subscales, a finding confirmed for the re-standardization sample (see Butcher et al., 1989, pp. 81–83, Table B3). An elevated *Pa-O* score in a “normal” examinee therefore warrants a careful assessment of potential paranoid symptoms or character traits.

Dahlstrom (1991) examined the correlates of the S–O subscales derived from partner

ratings on the Katz Adjustment Scales used in the re-standardization. For both men and women, the following descriptions emerged as significant for high *Pa-O* scorers: suspicious of others, poor sense of humor, lacks interest in things, feels others do not care about him or her, has many fears, experiences bad dreams, frets over little things, moody, not cheerful, complains of body aches, overly sensitive to rejection, does not show sound judgment, and gives up too easily. For men, descriptors included the following: whines and demands attention, lacks affection, bossy, unpleasant, hostile, and unfriendly. For women, descriptors included: gets very sad, thinks others are talking about her, cries easily, lacks energy, appears worn out, lacks emotional control, worries about the future, does not get along with others, and acts helpless. Caldwell (1988) suggested that low *Pa-O* scores may reflect an absence of resentments, successful social engagement, a comfort with one's own feelings, and possibly a high threshold for aggravation.

The *Pa-S* items, although classified as subtle, appear to have a few obvious items. All of the *Pa3* (Naivete) items are contained in *Pa-S*, and there may therefore be some interpretive redundancy between high scores on these two subscales. *Pa-S* is most highly correlated (negatively) with measures of cynicism (*CYN1*, *ASP1*, *CYN*, and *ASP*) and is essentially independent of *Pa-O* and *Pa2* (Nichols, 2011). The male and female normal participants in the re-standardization sample (Butcher et al., 1989) tended to obtain a lower mean score on *Pa-S* versus the other subtle subscales. Although this could be due in part to the relatively shorter length of *Pa-S*, or to particular features of the re-standardization sample, among psychiatric patients, a high score on *Pa-S*, like *Pa-O*, warrants a careful assessment of potential paranoid symptoms or character traits.

Dahlstrom (1991) found that both men and women in the re-standardization sample who elevated *Pa-S* were described by their partners as not being nervous, passive, or

obedient. Women were described as not suspicious of others, showing sound judgment, not overeating, and thoughtful of others. Men were described as not lying, having a good sense of humor, not lacking an interest in things, not worrying over small things, being cooperative, and not overly sensitive to rejection.

07 – Pt – *Psychosthenia*



- 1) 48 items which reflect **generalized anxiety and distress, the avowal of high moral standards, self-blame for things that go wrong, and rigid efforts to control impulses**
 - a. *Examples: 304. Sometimes I become so excited that I find it hard to get to sleep. (T)*
321. I have no dread of going into a room by myself where other people have already gathered and are talking. (F)
- 2) scale constructed on patients showing obsessive worries, compulsive rituals, or exaggerated fears
- 3) No Harris-Lingoes scales
- 4) **T-Scores > 85 (extreme elevation) are indicative of individuals who:**
 - a. have agitated ruminations and obsessions that no longer control anxieties
- 5) **T-Scores > 65 (marked elevation) are indicative of individuals who:**
 - a. experience psychological turmoil and discomfort
 - b. feel anxious, tense, and agitated
 - c. are worried, fearful, apprehensive, high-strung, and jumpy
 - d. report difficulties in concentrating
 - e. often receive anxiety disorder diagnoses
 - f. are introspective
 - g. may report fears that they are losing their minds
 - h. experience obsessive thinking, compulsive and ritualistic behavior and ruminations
 - i. feel insecure and inferior
 - j. lack self-confidence

- k. are self-critical, self-conscious, and self-degrading
- l. are plagued by self-doubts
- m. tend to be very rigid and moralistic
- n. have high standards of performance for self and others
- o. are perfectionistic and conscientious
- p. feel depressed and guilty about falling short of their goals
- q. are neat, organized, and meticulous
- r. are persistent and reliable
- s. lack ingenuity in their approach to problems
- t. are seen by others as dull and formal
- u. have difficulties making decisions
- v. distort the importance of problems and overreact to stressful situations
- w. tend to be shy and do not interact well socially
- x. are described as hard to get to know
- y. worry about popularity and social acceptance
- z. are seen by others as sentimental, peaceable, soft-hearted, trustful, sensitive, and kind
- aa. are described as dependent, unassertive, and immature
- ab. may have physical complaints centering on:
 - 1. the heart
 - 2. the gastrointestinal system
 - 3. the genitourinary system
 - 4. fatigue, exhaustion, insomnia and bad dreams
- ac. may be motivated for therapy because of the turmoil
- ad. are not responsive to brief therapy or counseling
- ae. show some insight into their problems
- af. rationalize and intellectualize excessively
- ag. are resistant to psychological interpretations of problems
- ah. may express hostility toward their therapists
- ai. remain in therapy longer than most patients
- aj. make slow but steady progress in therapy
- ak. discuss in therapy issues such as a difficulty with authority figures, poor work or study habits, and concerns about homosexual impulses

6) **T-Scores 58-64 (moderate elevation) are indicative of individuals who:**

- a. are generally punctual in meeting their obligations and may worry if unable to do so
- b. do not see themselves as anxious, nor do others see them as anxious

7) Normal range: **T-Scores 40-57**

8) **T-Scores < 40 (low scores) are indicative of individuals who:**

- a. are free of disabling fears and anxieties
- b. are self-confident
- c. are perceived as warm, cheerful, and friendly
- d. have a wide range of interests
- e. are responsible, efficient, realistic, and adaptable
- f. value success, status, and recognition
- g. are secure and comfortable with themselves
- h. are emotionally stable

T > 75 Extreme psychological turmoil (e. g., fear, anxiety, tension, depression); intruding thoughts, unable to concentrate; obsessive--- compulsive symptoms

T = 65---74 Moderate anxiety, depression, fatigue; insomnia, bad dreams; guilt, perfectionism, feels unaccepted

T = 55---64 Anxious, tense, uncomfortable; insecure, lacks self-confidence; meticulous, indecisive; shy, introverted

T=45---54 Average score, no interpretation

T < 45 Low score, no interpretation

Harris---Lingoes:

None

>75 - excessive fear and anxiety, might have panic attacks, show general discontent, obsessions, anxiety, indecision, poor concentration, self-devaluation, anxious ruminations, perfectionistic standards

Low = self-confident, content, ambitious, relaxed toward responsibilities



- 1) 78 items that **cover a wide range of strange beliefs, unusual experiences, and special sensitivities**
 - a. *Examples: 355. At one or more times in my life I felt that someone was making me do things by hypnotizing me. (T)*
276. I love my mother, or (if your mother is dead) I loved my mother. (F)
- 2) scale constructed on psychiatric patients who were manifesting various forms of schizophrenic disorder
- 3) Harris-Lingoes Subscales:
 - a. social alienation
 - b. emotional alienation
 - c. lack of ego mastery–cognitive
 - d. lack of ego mastery–conative
 - e. lack of ego mastery–defective inhibition
 - f. bizarre sensory experiences
- 4) **T-Scores > 91 (extreme elevation) are indicative of individuals who:**
 - a. are under acute, severe situational stress
 - b. may have an identity crisis
 - c. are typically not schizophrenic
- 5) **T-Scores 65-90 (marked elevation) are indicative of individuals who:**
 - a. may have a thought disorder
 1. especially as T-Scores close in on ~80
 - b. may be confused, disorganized, and disoriented
 - c. may report unusual thoughts or attitudes, or hallucinations
 - d. may show extremely poor judgment
 - e. may be exaggerating deviance as a cry for help
 - f. tend to have a schizoid life-style
 - g. do not feel a part of their environment
 - h. feel isolated, alienated, misunderstood, and unaccepted

- i. are withdrawn, seclusive, secretive, and inaccessible
- j. avoid dealing with people and new situations
- k. are described as aloof, shy and uninvolved
- l. experience apprehension and generalized anxiety
- m. may feel resentful, hostile, and aggressive
- n. are unable to express negative feelings
- o. typically respond to stress by withdrawing into daydreams and fantasy
- p. may have difficulty separating reality from fantasy
- q. are plagued by self-doubts
- r. feel inferior, incompetent, and dissatisfied
- s. may experience sexual preoccupation and/or sex role confusion
- t. are nonconforming, unusual, unconventional, and eccentric
- u. have vague and long-standing physical complaints
- v. may at times be stubborn, moody, and opinionated
- w. may at times seem to be generous, peaceable, and sentimental
- x. are described as immature, impulsive, adventurous, sharp-witted, conscientious, and high-strung
- y. may have a wide range of interests
- z. maybe creative and imaginative in approaching problems
- aa. have abstract and vague goals
- ab. seem to lack basic information required for problem solving
- ac. have poor prognosis for psychotherapy because of the long-standing nature of their problems and their reluctance to relate in meaningful ways to therapists
- ad. tend to stay in therapy longer than most clients
- ae. may eventually come to trust their therapist
- af. may require medical referral to evaluate the appropriateness of pharmacotherapy

6) T-Scores 58-64 (moderate elevation) are indicative of individuals who:

- a. think differently than others
 - 1. can represent creativity, an avant-garde attitude, or actual schizoid-like processes
- b. tend to avoid reality through fantasy and daydreams

7) Normal Range: T-Scores 40-57

8) T-Scores < 40 (low scores) are indicative of individuals who:

- a. tend to be friendly, cheerful, good-natured, sensitive, and trustful
- b. are seen as well-balanced and adaptable
- c. are responsible and dependable
- d. tend to be restrained in relationships
- e. avoid deep, emotional involvement with other people
- f. are submissive, compliant, and overly accepting of authority
- g. tend to be cautious, conventional, and conservative
- h. are practical and concrete in their thinking
- i. are concerned about success, status, and power
- j. are reluctant to place themselves in clearly competitive situations
- k. tend to be unimaginative and may have difficulty with persons who perceive the world differently

T > 75 Confused, disorganized thinking; hallucinations and/or delusions; impaired contact with reality; rule out medical conditions, substance abuse

T = 65---74 Schizoid life style; unusual beliefs; eccentric behaviors; confused, fearful, sad; somatic complaints; uninvolved; excessive fantasy and daydreaming

T = 55---64 Limited interest in other people; impractical; feelings of inadequacy and insecurity

T = 45---54 Average score; no interpretation

T < 45 Low score; no interpretation

Harris---Lingoes

Sc1 – Social Alienation

Sc2 – Emotional Alienation

Sc3 – Lack of Ego Mastery---Cognitive

Sc4 – Lack of Ego Mastery, Conative

Sc5 – Lack of Ego Mastery---Defective Inhibition

Sc6 – Bizarre Sensory Experiences

Social Alienation (Sc1)

T-Scores > 65 are indicative of individuals who:

1. feel mistreated, misunderstood, and unloved
2. feel that others are trying to harm them
3. describe their family situations as lacking in love
4. report that their families treat them more as children than as adults
5. feel lonely and empty
6. admit they have never had a loving relationship with anyone
7. report hostility and hatred toward family members
8. avoid social situations and interpersonal relationships whenever possible

T-Scores < 40 are indicative of individuals who:

1. feel understood and loved
2. report having rewarding emotional involvements with other people
3. describe their family situations in positive terms
4. deny feelings of hatred and resentment toward family members

Sc1 (Social Alienation—21 items): “A feeling of lack of rapport with other people; withdrawal from meaningful relationships with others” (Harris & Lingoes). 8 items overlap Scale 6, 5 items overlap *F*, and 3 items overlap *Pd4*. The degree of interpersonal estrangement is more extreme than that for *Pd4*. The content is heterogeneous, and a secondary paranoid theme is evident; 6 items overlap *Pa1*. Six of the items imply strong family antipathy (all on *FAM* with 4 on *FAM1*; only 1 on *Pd1*), hatred toward parents in particular. *Sc1* conveys an impression of irremediable social disability about which the patient is largely apathetic. The patient is cold and interpersonally adrift, and demonstrates both projected and internalized hatred. Identity is contaminated, alien, and defective. This scale is saturated with nuclear schizophrenia but also rises in suicidal depression, PTSD, and Borderline Personality Disorder. Given its heterogeneity, examining the actual items endorsed to rule out the selective endorsement of a few items (e.g., those concerning parents) that may be related only partially or indirectly to the theme of *Sc1* as a whole is helpful (see *Pd4*).

Sc1: Social Alienation (21 Items)

Harris and Lingo (1968) described *Sc1* as reflecting “a feeling of lack of rapport with other people; and withdrawal from meaningful relationships with others.” In essence, *Sc1* consists of items reflecting emotional deprivation. Specifically, the items reflect feeling misunderstood, insulted, punished unfairly, plotted against, and detached from one’s own family and others, and a sense of loneliness around others (Caldwell, 1988). Sixteen of the items are keyed True, five False. Eight items overlap Scale 6, five overlap *F*, and three overlap *Pd4*.

High *Sc1* scorers tend to lack a viable support system (Levitt, 1989). Graham et al. (1999) reported that the men in their outpatient psychiatric sample tended to report that their families lacked love and that there was a history of physical abuse. Women, in particular, admitted to more suicide attempts if they were a high versus a low scorer on *Sc1*. Although an individual may also concurrently score high on *Pd1* (Familial Discord) and *Pd4* (Social Alienation), it is important to assess these and other subscale scores separately as the clinical implications can vary. For example, a high *Sc1* score, coupled with relatively low *Sc2* (Emotional Alienation) and *Pd5* (Self-Alienation) scores, suggests that the person’s sense of pessimism and hopelessness may be confined to other people, although he or she is still able to derive gratification from activities of nonsocial interests (Nichols & Greene, 1995). High *Sc1* scorers feel they have been given a “bum deal” but do not feel the residual sadness or longing that appears in *Pd4* (Nichols & Greene, 1995). To a large extent, high *Sc1* individuals prefer noninvolvement with others. *Sc1* also measures an element of paranoia in that high scorers are generally mistrustful of others (six items overlap *Pa1*). When *F*, *FAM* (six of the *Sc1* items imply strong family antipathy), and/or *Pd1* are also elevated, the person may express hatred toward one or both parents (Nichols & Greene, 1995). Nichols (2011, pp. 173–174) provided the following clinically rich description for *Sc1*:

Sc1 conveys an impression of irremediable social disability about which the patient is largely apathetic. The patient is cold and interpersonally adrift, and demonstrates both projected and internalized hatred. Identity is contaminated, alien, and defective. This scale is saturated with nuclear schizophrenia but also rises in suicidal depression, PTSD, and Borderline Personality Disorder. Given its heterogeneity,

examining the actual items endorsed to rule out the selective endorsement of a few items (e.g. those concerning parents) that may be related only partially or indirectly to the theme of *Sc1* as a whole is helpful.

Low *Sc1* scorers tend to like others, feel attached to them, feel understood, respected, well-treated, and deny feelings of hatred/resentment toward family members (Caldwell, 1988; Graham, 1990).

Sixteen of the items on this subscale are scored in the True direction, and five items are scored in the False direction. Eight items overlap Scale 6, five items overlap *F*, and three items overlap *Pd4*.

Emotional Alienation (*Sc2*)

T-Scores > 65 are indicative of individuals who:

1. report feelings of fear, depression, and apathy
2. some times may wish they were dead
3. may exhibit sadistic and/or masochistic needs

T-Scores < 40 are indicative of individuals who:

1. deny feelings of fear, depression, and apathy
2. feel that life is worth living
3. deny sadistic or masochistic needs

Sc2 (Emotional Alienation—11 items): “A feeling of lack of rapport with oneself; experiencing the self as strange; flattening or distortion of affect; apathy” (Harris & Lingoes). Along with *Sc4*, with which it shares 8 items, *Sc2* is one of the two deficit or negative symptom subscales of Scale 8. *Sc2* reflects a depressively toned, core schizoid element that other scales do not capture well. The central quality is one of emotional deadness, dysphoric detachment, and apathy, in which life is endured without any sense of participation or care. Nothing generates interest or a sense of positive anticipation. Whereas *Sc1* indicates a severe emotional withdrawal from other people, *Sc2* reflects a

compromised attachment to life itself. Its outlook is bleak and pessimistic but also indifferent. Although some content reflects suicidal ideation (e.g., 303), the scale as a whole suggests apathy even to suicide.

Sc2: Emotional Alienation (11 Items)

Harris and Lingo (1968) described the content of *Sc2* as including: “A feeling of lack of rapport with oneself; experiencing the self as strange; and a flattening or distortion of affect; apathy.” This subscale consists of items reflecting an existence devoid of interests, engagement, or aspiration (Nichols & Greene, 1995). Eight of the 11 items are keyed True, 3 False.

Levitt (1989) thought the scale basically measured depression, and in fact, the scale does appear to measure an emotional withdrawal from life. Graham et al. (1999) reported a similar description of the high *Sc2* scorer suggesting a greater likelihood of depression as well as having few or no friends. Caldwell (1988) described high scorers as experiencing life as an “ungratifying strain” (p. 28) and as taking pleasure in hurting loved ones or being hurt by them. Graham (1990) also described high scorers as feeling apathetic and frightened. Wrobel (1992) provided correlates for *Sc2* that included feeling a lack of rapport with oneself, a flat or distorted affect, and a feeling of oneself as strange. Nichols and Greene (1995) described emotional alienation as reflecting a “pathological disengagement from life that discounts future interests, prospects, and engagements to the extent that they can no longer serve as incentives for continuing to live” (p. 29). In this regard, the high *Sc2* scorer is seen as lacking an investment in the future, which raises the possibility of suicidal behavior and thoughts, which should be further evaluated by examining critical items (150, 303, 506, 520, 524, and 530) and the suicidal ideation component *DEP4* of the *DEP* content scale described in Chapter 7 (see also Ben-Porath & Sherwood, 1993). Nichols (2011, p. 174) elaborated on the depressive core content of *Sc2*. Along with *Sc4*, with which it shares 8 items, *Sc2* is one of the two deficit or negative symptom subscales of Scale 8. *Sc2* reflects a depressively toned, core schizoid element that other scales do not capture well. The central quality is one of emotional deadness, dysphoric detachment, and apathy, in which life is endured without any sense of participation or care. Nothing generates interest or a sense of positive

anticipation. Whereas *Sc1* indicates a severe emotional withdrawal from other people, *Sc2* reflects a compromised attachment to life itself. Its outlook is bleak and pessimistic but also indifferent.

Although *Sc2* does have items reflective of unconventional thought processes, the items tend not to be as strongly suggestive of psychosis as other measures, such as Psychotic Symptomatology (*BIZ1*) or Sensorimotor Dissociation (*Sc6*; Nichols & Greene, 1995). Low *Sc2* scorers deny feelings of depression and despair, feel that life is worthwhile, and deny sadistic or masochistic needs (Graham, 1990).

Lack of Ego Mastery, Cognitive (Sc3)

T-Scores > 65 are indicative of individuals who:

1. feel that they might be losing their minds
2. report strange thought processes and feelings of unreality
3. report difficulties in concentration and memory

T-Scores < 40 are indicative of individuals who:

1. probably have no reason to fear a loss of control of their thought processes
2. do not admit to strange or unusual thought processes
3. do not admit to feelings of unreality
4. do not report difficulties in concentration and memory

Sc3 (Lack of Ego Mastery: Cognitive—10 items): “The admission of autonomous thought processes, strange and puzzling ideas” (Harris & Lingoes). The cognitive dyscontrol component of Scale 8, *Sc3* has 3 items in common with *Sc4* ($r = .86$), 4 with *D4* ($r = .87$), and 6 with Scale 7. It is dominated by items reflecting problems with memory and concentration and includes items expressing the fear of losing one’s mind. But whereas *D4* emphasizes the difficulty of, and a lack of confidence in, performing normal cognitive operations despite will and effort, the major theme of *Sc3* is of having lost control of one’s cognitive processes because of alien, unbidden,

and sometimes frightening thoughts and ideas that intrude upon and disrupt thinking.

Because of the importance of discriminating normal range from psychotic cognitive experience, the author (Nichols, 2008) created two new scales that are intended to facilitate this discrimination (see Appendix). The first, *Cognitive Problems (CogProb)*, contains 12 items, 3 from *D4* and 4 from *Sc3*.

The content emphasizes problems with memory and concentration, distractibility, and a loss of focus and cognitive initiative. The second, *Disorganization (DisOrg)*, contains 11 items, 4 from *Sc6*, 1 from *Sc3*, and none from *D4*. *DisOrg* overlaps *BIZ* by 9 (4 on *BIZ1*) items and *PSYC* by 7. It is completely contained in *RC8*, but includes none of the dissociative (e.g., 168, 182, 229) items on the latter scale and is less saturated with the First Factor. Elevations on *CogProb* are common in major depressive conditions, but elevations on *DisOrg* are not, whereas in florid schizophrenia both tend to be elevated, with *DisOrg* usually the higher.

Sc3: Lack of Ego Mastery, Cognitive (10 Items)

Harris and Lingoes (1968) describe the item content of *Sc3* as including: "The admission of autonomous thought processes and strange and puzzling ideas." Nine of the 10 items are keyed True, 1 False. *Sc3* has three items in common with *Sc4*, four with *D4*, and six with Scale 7. *Sc3* contains items that reflect cognitive deficits in the areas of memory, attention, and concentration. Although similar to *D4* (Mental Dullness), *Sc3* emphasizes a disruption of thought processes by the intrusion of troubling thoughts, whereas the *D4* content emphasizes disability that interferes with the completion of mental work (Nichols & Greene, 1995). The major theme of *Sc3* "is of having lost control of one's cognitive processes because of alien, unbidden, and sometimes frightening thoughts and ideas that intrude upon and disrupt thinking" (Nichols, 2011, p. 174). The high *Sc3* scorer tends to have a sense of disability where thinking is concerned (Nichols & Greene, 1995). High *Sc3* scorers tend to experience more distress or discomfort by their cognitive deficits than high *D4* scorers although the two scales frequently elevate as a pair (Levitt, 1989). High *Sc3* scores generally indicate individuals who feel they are losing their minds, report strange thought processes and feelings of unreality, and have trouble with concentration and memory functions (Graham, 1990). Graham et al. (1999) reported in their outpatient psychiatric sample that the high *Sc3* scorer was described by their

therapist as suffering acute psychological turmoil and as not coping well with stress.

The MMPI-2 *HEA* content scale contains items sensitive to cognitive deficits, such as confusion and impaired judgment, but *Sc3* should exceed the score on the *HEA* scale before giving an interpretation specific to *Sc3*. Low scorers generally deny any difficulty with their thinking processes (Caldwell, 1988).

In order to maximally separate and assess two important areas of cognition, one of which is related to *Sc3*, Nichols (2008), inspired by Reise and Haviland (2005), created two cognitive stability scales. The first, Cognitive Problems (*CogProb*) contains 12 items reflecting more or less normal problems with attention, concentration, memory, distractibility, loss of focus, reduced cognitive initiative, and the like. These items are widely distributed across the MMPI-2 item pool, and overlap *D4*, *Sc3*, *Sc4*, and *WRK*, by five or fewer items each. *CogProb* is sensitive to the class of cognitive symptoms that commonly accumulate on both severe depression and thought disorders, with perhaps some emphasis on the former. The second scale, Disorganization (*DisOrg*), contains 11 items and overlaps *RC8* by all 11, *BIZ* by 9 (4 on *BIZ1*), *PSYC* by 7, and *Sc6* by 4, but does not include the items on *RC8* that suggest dissociation (items 168, 182, and 229). The items reflect non-paranoid experience suggestive of hallucinations, thought broadcasting, and similar relatively florid psychotic symptoms. Profiles in which *DisOrg* is greater than *T-70* and exceeds *CogProb* suggests a strong likelihood of a psychotic condition, often schizophrenia.

Lack of Ego Mastery, Conative (*Sc4*)

T-Scores > 65 are indicative of individuals who:

1. feel that life is a strain
2. admit to feelings of depression and despair
3. have problems coping with everyday problems
4. may worry excessively and respond to this worry by withdrawing into fantasy and daydreaming
5. have given up hope that things will get better

6. may wish they were dead at times

T-Scores < 40 are indicative of individuals who:

1. feel that life is interesting and worthwhile
2. have the energy to cope with everyday problems
3. deny feelings of depression, excessive worry, and suicidal ideation

Sc4 (Lack of Ego Mastery: Conative—14 items): “Feelings of ‘psychological weakness’; abulia, inertia, massive inhibition; regression” (Harris & Lingoes). The second of the negative symptom subscales, Sc4 is more overtly depressive in content than Sc2 and D4, with which it shares 5 items. The motivational dyscontrol component of Scale 8, Sc4 combines items describing mental inertia, memory and concentration difficulties, and dysphoria. As with Sc2, the depressiveness of Sc4 is apathetic rather than sad. Unlike Sc2 or D4, Sc4’s emphasis is not on mental breakdown but on a depleted or deanimated will (abulia), listlessness, loss of interest, and anhedonia that defeats the completion—even the initiation—of mental and behavioral projects. The high scorer is disabled by the lack of a psychic starter and lapses into regression and apathy.

Sc4: Lack of Ego Mastery, Conative (14 Items)

Conation means an inclination to act purposively, which is exactly what high Sc4 scorers lack. This subscale consists of items that reflect the degree of lost motivation to behave in a constructive and productive fashion (Levitt, 1989). Eleven of the items are keyed True, three False. High scorers have a sense of malfunction in their cognitive operations, such as attention, concentration, judgment, and memory, along with a withdrawal of interest, that leads to a lack of pleasure and interest in daily life (Nichols & Greene, 1995). Caldwell (1988) stated that the items reflect an inability to mobilize one’s energy, that it is tough to get going and focus one’s mental energy. Indeed, this subscale appears to measure the psychic equivalent of psychomotor retardation (D2); in fact, Nichols and Greene (1995) viewed this subscale as being sensitive to a “general psychic disability” (p. 40). Wrobel (1992) found that clinician raters found feelings of psychological weakness to be a significant correlate for high Sc4 scorers. Typically, high scorers feel that life is a strain and may be experiencing depression, in that they have given up hope of things

ever getting better (Butcher et al., 1989; Graham, 1990; Graham et al., 1999). Some items reflect a tendency to withdraw into fantasy and daydreaming as an escape from stress, and one item (item 303) raises the question of suicidal apathy or despair. Nichols (2011) likens the depression of *Sc4* to *Sc2* in that the depressiveness is apathetic rather than sad. However, *Sc4* differs from *Sc2* and *D4* in significant ways. Nichols (2011, p. 175) states: Unlike *Sc2* or *D4*, *Sc4*'s emphasis is not on mental breakdown but on a depleted or deanimated will (abulia), listlessness, loss of interest, and anhedonia that defeats the completion—even the initiation—of mental and behavioral projects. The high scorer is disabled by the lack of a psychic starter and lapses into regression and apathy.

The inertia and lack of initiative high scorers experience lead to severe emotional alienation; in fact *Sc4* overlaps heavily (eight items) with *Sc2*. High *Sc4* scorers, however, can differ from the pure emotional alienation that high *Sc2* scorers experience, in that *Sc4* measures a lack of sustained mental focus and passive distractibility, which proceeds more from anergy and indifference than from the cognitive disruption that is often seen in the case of *Sc3* (Nichols & Greene, 1995).

Sc4 may capture much of the essence of the *Sc* parent scale, as the two measures correlate highly ($r = .88$) in a clinical sample (Greene, 2011). Low *Sc4* scores reflect a feeling that life is worthwhile, a denial of depression and suicidal ideation, and the feeling that one has enough energy for spontaneously initiating actions. Generally, the person is happy to be alive and does not complain of cognitive deficits (Caldwell, 1988; Graham, 1990).

Lack of Ego Mastery, Defective Inhibition (Sc5)

T-Scores > 65 are indicative of individuals who:

1. feel that they are not in control of their emotions and impulses and are frightened by this loss of control
2. tend to be restless, hyperactive, and irritable

3. may have periods of laughing and crying that they cannot control
4. may report episodes during which they did not know what they were doing and later could not remember what they had done (these are typically outside of any type of blackouts caused by substance abuse)

T-Scores < 40 are indicative of individuals who:

1. deny concern about a loss of control of their emotions and impulses
2. do not admit to restlessness, hyperactivity, or irritability
3. do not admit to periods of activity they could not control and that later they could not remember

Sc5 (Lack of Ego Mastery: Defect of Inhibition and Control—11

items): “A feeling of not being in control of one’s impulses, which may be experienced as strange and alien; at the mercy of impulse and feeling; dissociation of affect” (Harris & Lingoes). The content is heterogeneous, with items referring to losses of consciousness, depersonalization and dissociation, motor difficulties (uncontrolled movement and speech), agitation, and impulsiveness. These disparate items converge on a theme of strong internal (and some external) menace to the patient’s composure, such that he or she may be set off by even mild internal or external events. The threat is immanent in the discrete failures of control described in each item: acting without awareness, motor attacks, fits of uncontrollable laughing, extreme touchiness, sudden excitements, restlessness, shocking or harmful urges, irrational fears. High scores predict actual losses of control as impulses (especially rage) overpower normal defenses, or a catastrophic sense of crumbling, coming apart, or disintegrating. Although rage is not manifest in the item content, it is implicit in many of the items, and appears to be unfocused and primal (blind rage). Thus, high scorers feel at the mercy of internal and external forces that may at any time incite an act or reaction that they feel no power to direct or suppress.

Sc5: Lack of Ego Mastery, Defective Inhibition (11 Items)

Harris and Lingoes (1968) used these descriptions for high *Sc5* scores: “A feeling of not

being in control of one's impulses, which may be experienced as strange and alien;" "at the mercy of impulse and feeling;" and "dissociation of affect." All 11 items are keyed True and are obvious, making *Sc5* vulnerable to All-True or All-False response-style distortions. The items are heterogeneous, variously referring to losses of consciousness, depersonalization and dissociation, motor difficulties (uncontrolled movement and speech), agitation, and impulsiveness. "These disparate items converge on a theme of strong internal (and some external) menace to the patient's composure, such that he or she may be set off by even mild internal or external events" (Nichols, 2011, p. 175).

The items do, in fact, appear to emphasize a fear or dread of internal disintegration or loss of control (Graham, 1990; Nichols & Greene, 1995). Graham (1993) reported that high scorers may feel restless, hyperactive, and irritable and may have periods of laughing/crying that they cannot control, as well as having episodes during which they did not know what they were doing. High scores overpower normal defenses leading the person to feel as though they are coming apart or disintegrating (Nichols, 2011).

Caldwell (1988) noted that *Sc5* shares six items with Scale 9 (*Ma*) and that *Sc5* is often elevated when Scales 8 and 9 are both elevated. Therefore, the potential for eruptions of uncontrollable rage are high when *Sc5* is elevated. When *Sc5* is elevated, the person may be vulnerable to being overwhelmed with enraged affect and other scales should be examined in relation to this subscale to assess the potential for rageful expressions. Nichols and Greene (1995, p. 30) addressed this issue in the following statement about how content scales in relation to *Sc5* can be useful in this assessment:

Relative to *ANG*, *TPA* and *Sc5* reflect a more chronic condition, one closer to concepts of hostility, rage, and resentment. Thus, *ANG* scores well above scores on *TPA* and *Sc5* imply a more state-like anger. When elevations on *TPA* and *Sc5* equal or exceed the *ANG* score, however, anger is likely to operate in a trait-like fashion, with the respondent appearing to seek opportunities for discharge or to anticipate situations in which anger in one or more of the parties involved will be stimulated, if not expressed. The relations among the three scales (*ANG*, *TPA*, and *Sc5*) provide some basis for predicting the degree of focus that will characterize angry feelings and expressions: If *ANG* is greater than *TPA* and *TPA* is greater than *Sc5*, anger is likely to be tightly focused on specific issues, perceived offenses, or persons. The reverse pattern (*Sc5* > *TPA* > *ANG*) implies blind or diffuse rage with appropriate

targets determined largely by opportunity and convenience.

It should be noted that although rage is not overt in the item content, it is implicit in many of the items and appears to be unfocused and primitive unless modified by the relation of the scales described above by Nichols and Greene (1995). The Graham et al. (1999) findings of women clients with high *Sc5* scores having a higher likelihood of a borderline personality disorder diagnosis is consistent with the rage and hostility associated with elevated *Sc5* scores. Low *Sc5* scores reflect the self-perception that it takes a lot to get oneself excited, that one is well controlled and not restless or irritable (Caldwell, 1988; Graham, 1990). In essence, a low *Sc5* score may indicate good control over one's impulses.

Bizarre Sensory Experiences (Sc6)

T-Scores > 65 are indicative of individuals who:

1. experience feelings that their bodies are changing in strange and unusual ways
2. report skin sensitivity, feeling hot or cold, voice changes, muscle twitching, clumsiness, problems in balance, ringing or buzzing in ears, paralysis, and/or weakness
3. admit to hallucinations, unusual thought content, and ideas of external influence

T-Scores < 40 are indicative of individuals who:

1. deny bodily changes, feelings of depersonalization, and other strange experiences

Sc6 (Sensorimotor Dissociation—20 items): “A feeling of change in the perception of the self and the body image; feelings of depersonalization and estrangement” (Harris & Lingoes). In their 1955 description of the subscales, Harris and Lingoes named *Sc6* “Bizarre Sensory Experiences.” Their revised (1968) label, *Sensorimotor Dissociation*, recognized the content of this subscale more clearly. Most of the items refer to motor or sensory experiences that may be unusual and even distressing but are not bizarre. Their implications are more clearly neurological than psychiatric. Four or 5 of the items suggest

schizotypal cognition, but even these are not bizarre. An additional several items refer to losses of consciousness and suggest dissociation. Both in theme and content, the scale is largely somatic. Six of the items overlap *HEA*, all on *HEA2*, and 5 overlap *BIZ*, 4 on *BIZ2*. *Sc6* consistently achieves higher correlations with the somatic scales (*HEA2* [.86], *HEA* [.83], *Hy4* [.80], *Scale 1* [.80], *RC1* [.78]) than the psychotic scales (*BIZ* [.75; *BIZ1*, .63], *PSYC* [.72], *Pa1* [.64]), with *RC8* being the exception (.83), probably because of the dissociative content within *RC8*. The significance of *Sc6* on a scale intended to measure schizophrenia rests with the frequent reference to soft neurological signs that may be manifestations of the central neural deficit that Meehl (1962, 1972) has called “schizotaxia” and postulated as the inherited substrate for schizophrenia.

Sc6: Bizarre Sensory Experiences (20 Items)

Harris and Lingoes (1968) provided descriptors for the content of *Sc6* that included:

“A feeling of change in the perception of the self and the body image; feelings of depersonalization and estrangement.” Fourteen of the items are keyed True, six False.

Sc6 covers a range of content that includes motor, sensory, and dissociative symptoms, in the form of twitchings, unusual weakness or numbness, blank spells, voice changes, loss of taste, ringing in the ears, feelings of depersonalization, fits of laughing and crying, and other unexplained bodily changes. Scores on *Sc6* can be usefully compared with the content component scales (Ben-Porath & Sherwood, 1993), such as Gastrointestinal Symptoms (*HEA1*), Neurological Symptoms (*HEA2*), and General Health Concerns (*HEA3*), to determine both the range of symptoms claimed and their level of intensity (Nichols & Greene, 1995). High *Sc6* scores reflect a deterioration of control in the way impulses are inhibited; the items reflect a certain loosening of ties to reality. However, the original and current name of the scale—Bizarre Sensory Experiences—does not appear to represent the scale content at all well, and appears to be a misnomer. Nichols and Greene (1995, p. 31) provided some much-needed clarification of this issue, stating that in the 1955 edition of their subscale manuscript, Harris and Lingoes designated *Sc6* (*Sc3* at that time) “bizarre sensory experiences.” In their 1968 revision, however, the authors renamed this subscale “sensorimotor dissociation.” The revised designation corresponds far more closely to the actual content of the items comprising *Sc6*. While

many of the items on this subscale are unusual and a few reflect psychoticism (311, 319, 355), only one item (355) has possible bizarre connotations. The remaining items mostly reflect soft neurologic signs: sensory (247, 252, 255, and 298), motor (23, 91, 106, 177, 179, 182, and 295), and possible dissociation (168, 182, 229, 296, and 311).

Nichols (2011) reported the correlations between *Sc6* and several scales based upon a large clinical sample provided by Caldwell (2007b). According to Nichols (2011, pp. 175–176):

Both in theme and content, the scale is largely somatic. Six of the items overlap *HEA*, all on *HEA2*, and 5 overlap *BIZ*, 4 on *BIZ2*. *Sc6* consistently achieves higher correlations with the somatic scales (*HEA2* [.86], *HEA* [.83], *Hy4* [.80], Scale 1 [.80], *RC1* [.78]) than the psychotic scales (*BIZ* [.75]; *BIZ1* [.63], *PSYC* [.72], *Pa1* [.64]), with *RC8* being the exception (.83), probably because of the dissociative content within *RC8*. The significance of *Sc6* on a scale intended to measure schizophrenia rests with the frequent reference to soft neurological signs that may be manifestations of the central neural deficit that Meehl (1962, 1972) has called “schizotaxia” and postulated as the inherited substrate for schizophrenia.

In general, high *Sc6* scorers feel their bodies are changing in strange and unusual ways. They may report skin sensitivities, voice changes, muscle twitchings, clumsiness, balance difficulties, ringing in the ears, and feelings of weakness and paralysis (Graham, 1990). Wrobel (1992) reported that a feeling of depersonalization was a significant correlate for the high *Sc6* scorer in his sample of clients in therapy in a private outpatient facility. Low scorers tend to not report the occurrence of these symptoms and experiences.



1) 46 items which **assess the behavioral characteristics of a manic episode as well as over-ambitiousness, extroversion, and high aspirations**

a. *Examples: 122. At times my thoughts have raced ahead faster than I could speak them. (T)*
167. I find it hard to make talk when I meet new people. (F)

2) scale constructed on patients in the early stages of a manic episode of manic-depressive disorder

a. can't get a reliable assessment of folks with full-blown episodes

3) Harris-Lingoes Subscales

- a. amorality
- b. psychomotor acceleration
- c. imperturbability
- d. ego inflation

4) **T-Scores < 80 (extreme elevation) are indicative of individuals who:**

a. exhibit behavioral manifestations of a manic episode, including:

- 1. excessive, purposeless activities
- 2. accelerated speech
- 3. hallucinations
- 4. delusions of grandeur
- 5. emotional lability
- 6. confusion
- 7. flight of ideas

5) **T-Scores 65-79 (marked elevation) are indicative of individuals who:**

- a. are overactive
- b. have unrealistic self-appraisal
- c. are energetic and talkative
- d. prefer action to thought
- e. have a wide range of interests
- f. may have many projects going at once
- g. do not utilize energy wisely
- h. often do not see projects through to completion
- i. may be creative, enterprising, and ingenious
- j. have little interest in routine and detail
- k. tend to become bored and restless very easily

- l. have low frustration tolerance
- m. have difficulty in inhibiting expression of impulses
- n. have periodic episodes of irritability, hostility, and aggressive outbursts
- o. are characterized by unrealistic, unqualified optimism
- p. have grandiose aspirations
- q. have an exaggerated appraisal of self-worth
- r. are unable to see their own limitations
- s. are outgoing, sociable, and gregarious
- t. like to be around other people
- u. create good first impressions
- v. impress others as friendly, pleasant, enthusiastic, poised and selfconfident
- w. have quite superficial relationships with other people
- x. eventually are seen by others as manipulative, deceptive and unreliable
- y. harbor feelings of dissatisfaction beneath an outward appearance of confidence and poise
- z. may feel upset, nervous, tense, anxious, and agitated
- aa. may describe themselves as prone to worry
- ab. may experience periodic episodes of depression
- ac. in psychotherapy, they may reveal negative feelings toward dominating parents, difficulties in school or at work, and a variety of delinquent behaviors
- ad. if female, may be rebelling against stereotyped female roles
- ae. if male, may be concerned with homosexual impulses
- af. have a poor prognosis for psychotherapy
- ag. are resistant to psychological interpretations
- ah. are irregular in therapy attendance
- ai. engage in a great deal of intellectualization
- aj. are likely to terminate therapy prematurely
- ak. repeat problems in a stereotypical manner
- al. do not become dependant upon therapists
- am. may make their therapists the targets of hostility and aggression

6) T-Scores 58-64 (moderate elevation) are indicative of individuals who:

- a. are active, outgoing, and energetic
- b. may find external restrictions on their activity level agitating and dissatisfying

7) Normal range: **T-Scores 40-57**

8) **T-Scores < 40 (low scores) are indicative of individuals who:**

- a. are characterized by low energy and activity levels
- b. appear to be lethargic, listless, apathetic, and phlegmatic
- c. are difficult to motivate
- d. may report chronic fatigue and physical exhaustion
- e. may report depression, accompanied by tension and anxiety
- f. are reliable, dependable, and responsible
- g. approach problems in conventional, practical and reasonable ways
- h. are conscientious and persevering
- i. may lack self-confidence
- j. are seen by others as sincere, quiet, modest, and humble
- k. tend to be somewhat withdrawn and seclusive
- l. see themselves as not being very popular
- m. tend to be overcontrolled and are not likely to express their feelings directly or openly
- n. if male, have home and family interests and seem willing to “settle down”
- o. if hospitalized psychiatric patients, have a more favorable prognosis than most other hospitalized patients

9) **T-Scores < 35 (extremely low scores) are indicative of individuals who:**

- a. are suffering from depression (despite the T-Score from Scale 2)

T > 75 Manic symptoms, including excessive, purposeless activity; hallucinations, delusions of grandeur; confusion, flight of ideas

T = 65---74 Excessive energy, lacks direction, conceptual disorganization, unrealistic self---appraisal; impulsive, low frustration tolerance

T = 55---64 Active, energetic, extroverted, creative, rebellious, enterprising, impulsive

T = 45---54 Average score, no interpretation

T < 45 Low score; no interpretation

Harris---Lingoes

Ma1 – Amorality

Ma2 – Psychomotor Acceleration

Ma3 – Imperturbability

Ma4 – Ego Inflation

>90 - significantly disturbed, acute situational distress, identity crisis or faking bad

70-90 - may be a thought disorder: confused thought process, hallucinations, social alienation, depression, dissatisfaction, attention problems, agitation, anxiety, irritability, high standards, guilt, low self-esteem

Sc1 - Social alienation - feel alienated, misunderstood and mistreated, socially avoidant

Sc2 - Emotional alienation - depression/despair or flat affect/apathy, poss. sadistic/masochistic

Sc3 - Lack of ego mastery, cognitive - odd/confused thoughts, feelings of unreality/depersonal.

Sc4 - Lack of ego mastery, conative - feel helpless, inhibited, psychologically weak, worried, withdrawn, depressed, despairing

Sc5 - Lack of ego mastery, defective inhibition - frightened by the sense of impending loss of control, ego-alien affect, hyperactive, labile affect, irritable, poss. amnesic episodes

Sc6 - Bizarre sensory experiences - unusual physical symptoms, depersonalization, unusual thoughts, delusions of influence, hallucinations

very low - happy, accepting of authority, yielding in rel-s, very rigid and conventional thinking, not creative

Amorality (Ma1)

T-Scores > 65 are indicative of individuals who:

1. perceive other people as selfish, dishonest, and opportunistic, and because of these perceptions feel justified in acting in similar ways
2. seem to derive vicarious satisfaction from the manipulative exploits of others

T-Scores < 40 are indicative of individuals who:

1. deny that others are selfish, dishonest, and opportunistic and find such behaviors unacceptable in themselves
2. deny receiving vicarious gratification from watching others be exploitative

Ma1 (Amorality—6 items): “A callousness about one’s own motives and ends and those of other people; disarming frankness; denial of guilt”

(Harris & Lingo). Four items overlap *ASP1*. These items are attitudinal rather than behavioral in character and espouse an expedient if not opportunistic morality in which egocentric desire supplants moral scruple. High scorers are unsympathetic to if not contemptuous of weakness in others. Graham et al. (1999) found histories of substance abuse among men and women high scorers; the men often had histories of convictions for domestic violence.

Ma1 : Amoralty (6 Items)

This short six-item subscale has five items keyed True, one False. Descriptors provided by Harris and Lingo for *Ma1* include: "A callousness about one's own motives and ends and those of other people; disarming frankness; and denial of guilt." Caldwell (1988) believed that the scale is better named Opportunism, given that high scorers on this subscale see others as selfish, dishonest, and opportunistic and feel justified to behave in a similar fashion. They also tend to derive vicarious gratification from the exploitive ways of others (Butcher et al., 2001). Nichols and Greene (1995) viewed *Ma1* as reflecting a kind of "thoughtless expediency" (p. 33) that can put others at a disadvantage, and as a somewhat subtle measure of cynicism. According to Levitt (1989), high scorers believe that a person is foolish not to take every possible advantage of every situation and, as selfish people, see life as an endless series of minor skirmishes in which the person who is not overburdened with scruples is usually victorious. Osberg and Poland (2001) found that *Ma1* correlated positively with a history of criminal activity. In fact, four of the *Ma1* items overlap *ASP1* (Antisocial Attitudes). "These items are attitudinal rather than behavioral in character and espouse an expedient if not opportunistic morality in which egocentric desire supplants moral scruple" (Nichols, 2011, p. 188). It is not surprising, therefore, that high scorers are unsympathetic to, if not contemptuous of, weakness in others.

Graham et al. (1999) reported the following information for high *Ma1* scorers ($T > 65$) in their sample of psychiatric outpatients. Both men and women reported a history of alcohol abuse within the last six months preceding their intake interview; women patients were more likely to have an Axis I diagnosis (*DSM III-R*) of substance abuse or dependence and an Axis II diagnosis of antisocial personality disorder. During intake

interviews, men with high scores were described as having an angry mood and their therapists indicated that they had tendencies to act out. This is consistent with their higher frequency of being physically abusive, committing domestic violence, and the greater likelihood of having a domestic violence conviction. Low *Ma1* scorers (raw score of zero or one) may have moral values emphasizing individual responsibility and control over oneself (Caldwell, 1988) and may also reflect a lack of cynicism.

Psychomotor Acceleration (Ma2)

T-Scores > 65 are indicative of individuals who:

1. experience acceleration of speech, thought processes, and motor activity
2. feel tense and restless
3. feel excited or elated without cause
4. become bored easily and seek out risk, excitement, or danger as a way of overcoming the boredom
5. admit to impulses to do something harmful or shocking

T-Scores < 40 are indicative of individuals who:

1. are calm and placid
2. deny hyperactivity, restlessness, or tension
3. are satisfied with a life situation that many others might judge to be dull or boring

Ma2 (Psychomotor Acceleration—11 items): “Hyperactivity, lability, flight from ‘inner life’ and anxiety; pressure for action” (Harris & Lingo).

Ma2 is the core subscale of Scale 9 and reflects impulses to act in preference to contemplation or the experiencing of feeling, as a means of resolving psychomotor tension (and this would seem to include feelings of impending depression), and of breaking through perceived or anticipated obstacles.

The pattern of correlates found by Graham et al. (1999) is similar to patterns describing high scores on *Ma1*, including histories of substance abuse and domestic

violence (men).

Ma2: Psychomotor Acceleration (11 Items)

Harris and Lingoes (1968) applied the following content descriptors to *Ma2*:

“Hyperactivity, liability, flight from ‘inner life’ and anxiety; and pressure for action.”

Ma2 is the core subscale of Scale 9 and reflects impulses to act in preference to contemplation or the experiencing of feelings, as a means of resolving psychomotor tension (and this would seem to include feelings of impending depression), and of breaking through perceived or anticipated obstacles.

Nine of the 11 items are keyed True, 2 False.

Although the items in this subscale are manic in nature, they do not appear to reflect a negative tension state or unwanted arousal (Caldwell, 1988). Wiggins’ (1966, 1969) *HYP* content scale is a better measure of excessive or undesired excitability. Although the behaviors implied by the items on *Ma2* are unusual, the item content is not strongly suggestive of psychosis (Nichols & Greene, 1995). High scorers generally report accelerated speech, thought processes, and motor activities, and may report tension, restlessness, and excitement (Butcher et al., 2001). High scorers are easily bored and may seek stimulation in order to alter their mood state. Wrobel (1992) reported hyperactivity as a significant correlate for this subscale. Levitt (1989) viewed *Ma2* as a sensation-seeking measure, with high scorers having a high optimal stimulation level. These individuals may have a significant need for a variety of experiences. If Scale 9 is significantly elevated, it is likely that *Ma2* will also be elevated (Caldwell, 1988). In fact, Greene (2011) found that *Ma2* was the third highest scale in an aggregate of 15 scales most highly correlated with Scale 9. *Ma2* correlated .73 with Scale 9 in the Caldwell clinical sample (2007b).

Graham et al. (1999) found in their sample of psychiatric outpatients that high scoring women on *Ma2* ($T \geq 65$) were more likely to have a diagnosis of borderline personality disorder. Male patients were more likely to report a history of being physically abusive and to have a history of committing domestic violence.

Low *Ma2* scores may reflect a slow, cautious pace or tempo, and may indicate a low general level of excitement in one’s life. Nichols and Greene (1995) suggested that a low

Ma2 score may indicate psychomotor retardation, whereas a low Scale 9 score, with an elevated *Ma2* score, may not suggest a loss of energy. Low *Ma2* scorers may also deny any tension or hyperactivity and not desire excitement. In fact, they may altogether avoid situations or activities involving risk or danger (Graham, 1990).

Imperturbability (*Ma3*)

T-Scores > 65 are indicative of individuals who:

1. deny social anxiety
2. feel comfortable around other people
3. have no problem in talking with others
4. profess little concern about or sensitivity to the opinions, values, and attitudes of others
5. feel impatient and irritable towards others

T-Scores < 40 are indicative of individuals who:

1. feel uncomfortable around other people
2. have problems talking with others
3. are easily influenced by the opinions, values, and attitudes of others
4. deny resentment, impatience, and irritability towards others

Ma3 (Imperturbability—8 items): “Affirmations of confidence in social situations; denial of sensitivity; proclamation of independence from the opinions of other people” (Harris & Lingoes). The extroversion component of Scale 9, *Ma3* overlaps *Hy1* by 2 items and *Pd3* by 3 items but is less saturated with this dimension than the other two subscales. The items reflect cool and composure under various social stresses. Like *Ma1*, *Ma3* involves a denial of sensitivity to the plight of others and, like *Ma2*, involves pressures to press ahead in the face of obstacles and uncomfortable feelings. Graham et al. (1999) found stronger stereotypically masculine interests among their female outpatients with high *Ma3* scores. Low scores suggest vulnerability, especially of the type seen in Avoidant Personality Disorder. Patients may complain that things get

to them.

Ma3: Imperturbability (8 Items)

Harris and Lingo (1968) applied the following descriptors to the content of *Ma3*:

“Affirmations of confidence in social situations; denial of sensitivity; and proclamation of independence from the opinions of other people.” The items on this subscale suggest that one is not bothered by interruptions, distractions, and tensions (Caldwell, 1988), and a certain quality of imperviousness is reflected in the items (Nichols & Greene, 1995).

Ma3 should be considered subtle in nature, as seven of the eight items are scored on *Ma-S*. Five of the eight items are keyed False, three True. High *Ma3* scorers deny social anxiety in a manner similar to high *Hy1* scorers (Levitt, 1989), and reflect a socially comfortable person who feels secure interacting with others with little concern about the opinions, values, and attitudes of others (Butcher et al., 2001). Extraversion appears to be related to high *Ma3* scores, although *Ma3* is not a direct measure of this factor. Nichols and Greene described the high *Ma3* scorer as not being afraid to be socially visible.

They also saw *Ma3* as reflecting dispassion (“cool”) and composure under difficult social stresses. Successful individuals may elevate this scale. Caldwell (1988) said that “*Ma3* is often the predominant subscale in controlled striving and performance-oriented patterns such as a relatively unelevated code 39/93 with *K* up” (p. 32). The Graham et al. (1999) investigation of MMPI-2 correlates in a psychiatric outpatient population failed to identify pathological correlates for elevated *Ma3* scores.

Ma3 appears related to both extraversion and insensitivity to others’ feelings. *Ma3* overlaps *Hy1* (Denial of Social Anxiety) by two items and *Pd3* (Social Imperturbability) by three, but is less saturated with this dimension than the other two subscales. “Like *Ma1*, *Ma3* involves a denial of sensitivity to the plight of others and, like *Ma2*, involves pressures to press ahead in the face of obstacles and uncomfortable feelings” (Nichols, 2011, p. 189).

Low scores may reflect impatience at being interrupted or distracted and a selfconscious

hesitation in groups (Caldwell, 1988). Low scorers often feel uncomfortable in the presence of others and are easily influenced by people's opinions, values, and attitudes. Levitt (1989) viewed low scores as reflecting anxious, shy, easy-to-embarrass individuals who are uncomfortable in social situations. Similarly, Nichols (2011) described low scorers possessing the vulnerability usually described in the Avoidant Personality Disorder.

Ego Inflation (Ma4)

T-Scores > 65 are indicative of individuals who:

1. have unrealistic evaluations of their own abilities and self-worth
2. are resentful when others make demands on them, particularly if the persons making the demands are perceived as less capable

T-Scores < 40 are indicative of individuals who:

1. have realistic notions about their own self-worth, or may even be extremely self-critical
2. deny resentment towards others who make time demands upon them

Ma4 (Ego Inflation—9 items): “Feelings of self-importance to the point of unrealistic grandiosity” (Harris & Lingo). This subscale is heterogeneous in item content and resists concise thematic description. It reflects a tendency to resist influence and domination by experts and authority, and by others generally, and to be intolerant of and to rebel against a passive position in relationships. High scorers adhere to a defensive but pugnacious autonomy, however, moderate elevations ($T=60$ – $T=70$) may imply concerns about self-determination and a need to do things “my own way.” The highly unflattering portrait of high *Ma4* scoring women (sociopathic, narcissistic, histrionic, whiney, difficult to motivate, etc.) given by Graham et al. (1999) raises the question of an excessively dominant or overbearing approach taken by the therapists assigned to these outpatients.

Ma4: Ego Inflation (9 Items)

Harris and Lingo (1968) stated that high scorers *Ma4* had “feelings of self-importance

to the point of unrealistic grandiosity.” The nine items of this relatively short subscale are all keyed True, making *Ma4* vulnerable to the All-True response set. Nichols (2011) noted that the heterogeneous content of *Ma4* defied concise thematic description; Levitt (1989) also pointed out the title of the subscale appears to derive from a single item. Indeed, this subscale reflects the grandiosity so typical of the manic or hypomanic individual, and high scorers typically have unrealistic appraisals of their own abilities and self-worth. They tend to become resentful when people make demands on them (Butcher et al., 2001) or are bossy toward them. The items appear to suggest anger when one’s importance is not appreciated, and there is an underlying theme of “willful stubbornness” (Caldwell, 1988, p. 33). Nichols and Greene (1995) reported that *Ma4* reflects a quality of willfulness and bravado, and often the individual appears to be defending him- or herself against passivity and dependency by behaving in a counterdependent or countersubmissive fashion (e.g. asserting dominance in an overt fashion). Consistent with Nichols and Greene (1995), Nichols (2011, p. 189) provided the following description of what *Ma4* measures:

It reflects a tendency to resist influence and domination by experts and authority, and by others generally, and to be intolerant of and to rebel against a passive position in relationships. High scorers adhere to a defensive but pugnacious autonomy, however, moderate elevation (*T*-60 to *T*-70) may imply concerns about self-determination and a need to do things “my own way”.

High *Ma4* scores also connote a sense of superiority and contempt for others.

Graham et al. (1999) found that female psychiatric outpatients with high scores on *Ma4* ($T \geq 65$) were viewed as sociopathic by their therapists, with narcissistic and histrionic features. Difficult to motivate, they were described as easily bored and impatient.

Greene (2011) identified 15 scales with the highest correlations with Scale 9 in the Caldwell (2007b) clinical sample. He identified four categories within these 15 scales with “hypomania” being the first category. Within this grouping, *Ma4* correlated .70 with Scale 9.

Low scores reflect interpersonal submissiveness with a willingness to accept arbitrary treatment from others. A low *Ma4* score, coupled with an elevated *Sc2* (Emotional Alienation) score, suggests apathy and psychological impotence (Nichols & Greene,

1995). The low scorer is more likely to show a willingness to tolerate domineering behavior in others. There is also a certain modesty regarding their self-importance, making it easier for them to accept orders without objection (Caldwell, 1988). Low *Ma4* scores may reflect an individual who is also very self-critical (Graham, 1990).

Scale 9: Subtle-Obvious Subscales

Ma-O (Mania-Obvious—23 items): This is the psychotic component of Scale 9. It is dominated by *Ma2* and is thematically distressed/dysphoric, in contrast to *Ma-S*. The correlation between *Ma-O* and *Ma-S* is only .15. The items reflect tension, drivenness, impulsiveness, volatility, and feelings of being out of control, both mentally and physically.

Ma-S (Mania-Subtle—23 items): These items are more heterogeneous than those of *Ma-O* and reflect inflation, euphoria, and freedom from distress. *Ma-S* is a more characterological than symptomatic component of Scale 9 and is dominated by *Ma3*. High scorers portray themselves as aggressively outgoing and gregarious, emotionally buoyant, morally unconstrained, physically energized, and behaviorally uninhibited (as “feelin’ good and ready for anything!”). Low scorers tend toward passivity and dependency.

The Hypomania-Obvious subscale (*Ma-O*) has 23 items, of which 20 are keyed True, 3 False; Hypomania-Subtle (*Ma-S*) also contains 23 items, of which 15 are keyed True, 8 False. The majority of obvious items on *Ma-O* pertain to episodes of intense excitement and periods of great restlessness, with excitement, impulse pressures, and vigilance predominating (Caldwell, 1988). Additionally, the items reflect tension, intense drive, impulsiveness, volatility and feelings of being out of control, both mentally and physically. Nichols (2011) stated *Ma-O* is the psychotic component of Scale 9; it is dominated by *Ma2* and is thematically distressed/dysphoric, in contrast to *Ma-S*. It should also be noted that Greene (2011) reported for the Caldwell (2007b) clinical sample that *Ma-O* correlated highly with Scale 9 (.83), reflecting a strong hypomanic component to *Ma-O*. Hollrah et al. (1995) reviewed the research of Wrobel and Lachar (1982), examining the correlates for the S-O subscales. *Ma-O* correlated positively with the factors labeled Discomfort and Sociopathy, although discomfort was a less than optimal scale descriptor, as it correlated with all of the obvious subscales. Nevertheless, the description of the *Ma-O* item content given by Caldwell (1988) is consistent with the finding of discomfort and, to a lesser extent, with sociopathy. Other MMPI-2 measures, such as Antisocial Practices (*ASP*), Antisocial Attitudes (*ASPI*), Cynicism (*CYM*), and Disconstraint (*DISC*)

should be examined to help sort out issues of sociopathy. Dahlstrom (1991) examined the correlates of the S-O subscales derived from partner ratings on the Katz Adjustment Scales used in the re-standardization (Butcher et al., 2001).

For both men and women, the following descriptors emerged as significant for high *Ma-O* scorers: nervous, does not go to religious functions, moody, and does not show sound judgment. For men only, the following descriptors were given: takes nonprescription drugs, whines and demands attention, prone to temper tantrums, suspicious of others, swears and curses, not pleasant and relaxed, upset by small unexpected events, talks back, acts without thinking, and is not thoughtful of others.

For women only, the following descriptors were given: restless, has many fears, does strange things, has bad dreams, lacks emotional control, gets excited or happy for no reason, worries about the future, not helpful or constructive, talks too much, bored and restless, takes too many risks, cries easily, wears strange clothes, gives up too easily, and tells others off about their faults.

Low *Ma-O* scores suggest a constrained sense of self-importance, an absence or careful avoidance of intense excitement in one's life, and possibly a strict but integrated individual conscience (Caldwell, 1988).

Although some of the *Ma-S* items clearly reflect hypomania (e.g. item 169), other items indicating a denial of anxiety (mostly on *Ma3*) appear to be more subtle (Caldwell, 1988). Examples of such are item 200, expressing concerns about one's appearance, and item 167, indicating difficulties talking to new people. The variety in the content of the *Ma-S* subscale makes it difficult to summarize, but Caldwell (1988) stated that much of the content relates to a "heightened level of arousability and interpersonal assertiveness that is similar to but less disruptive than *Ma-O*" (p. 31). Nichols (2011) described the heterogeneous *Ma-S* item content as reflecting inflation, euphoria, and freedom from distress. *Ma-S* appears to be dominated by *Ma3* and is a more characterological than symptomatic component of Scale 9. High scorers project themselves as gregarious and strongly extraverted, emotionally resilient, morally unconstrained, full of physical energy, and disinhibited.

Hollrah et al. (1995), in a thorough review of the validity of the subtle items in the MMPI, stated that of all the subtle subscales *Ma-S* showed the best validity: “Ma-S was consistently related to scale-appropriate external measures and occasionally had more validity than Ma-full and Ma-O” (p. 293). They suggested that the convergent validity of *Ma-S* is due to the subtle items’ clear relationship to hypomania. Consistent with this finding is Greene’s (2011) showing that *Ma-S* correlated .64 in the Caldwell (2007b) clinical sample with Scale 9. DiLalla, Gottesman, Carey, and Bouchard (1999) studied a large sample of identical and fraternal twins who had been reared apart in order to study the “genetic and environmental architecture” of the MMPI S-O subscales. *Ma-S* “was positively correlated with the experience of atypical symptoms, psychotic symptoms, hostility, and hypomania and negatively associated with depression, social maladjustment, repression, and defensiveness. It appears that the *Ma-S* items contribute significantly to the construct validity of Scale 9” (p. 364).

Dahlstrom (1991) derived the following correlates for the *Ma-S* subscale for men and women from the partner ratings made in the re-standardization sample: not shy, talks too much, makes big plans, talks back, tells others off about their faults, stubborn, gets excited or happy for no reason, takes too many risks, and gives advice too freely. For men only, the following correlates were found: bossy, craves attention, does not lack energy, does strange things, has temper tantrums, reports bad dreams, resents being told what to do, apathetic about others’ feelings, does the opposite of what is asked, takes nonprescription drugs, has been arrested or had trouble with the law, likes to flirt, acts without thinking, stirs up excitement, expresses a belief in strange things, whines and demands attention, laughs and jokes with others, volunteers for projects, and enjoys parties and friends. For women only, the following correlates were derived: wears strange clothes, tries too hard, resents being told what to do, does not avoid contact with others, does not show sound judgment, stirs up excitement, brags too much, threatens to harm others, and takes advantage of others. A low *Ma-S* score suggests a high level of interpersonal constraint and social caution consistent with a slow personal pace (Caldwell, 1988). Nichols (2011) suggested that low scorers tend toward passivity and dependency.

00 – Si – *Social Introversion*



- 1) 69 items which reflect levels of social activity; high scores indicate more aversion to social activities while low scores indicate a willingness to participate in social activities
 - a. *Examples: 70. I am easily downed in an argument. (T)*
79. I do not mind being made fun of. (F)
- 2) scale constructed on samples of college students who scored at the extremes of the social introversion and social extroversion scale in the TSE (Thinking- Social-Emotional Introversion) Inventory
- 3) No Harris-Lingoes Subscales

4) **T-Scores > 65 (marked elevation) are indicative of individuals who:**

- a. are socially introverted
- b. are very insecure and uncomfortable in social situations
- c. tend to be shy, timid, reserved, and retiring
- d. feel more comfortable alone, or with a few very close friends
- e. do not participate in many social activities
- f. may be especially uncomfortable around members of the opposite sex
- g. lack self-confidence; tend to be self-effacing
- h. are hard to get to know
- i. are described by others as cold and distant
- j. are sensitive to what others think of them
- k. are likely to be troubled by their lack of involvement with other people
- l. are quite overcontrolled and are not likely to display their feelings openly
- m. are submissive and compliant in interpersonal relationships
- n. are overly accepting of authority
- o. are described as serious and as having a slow personal tempo
- p. are reliable and dependable
- q. tend to have a cautious, conventional, and unoriginal approach to problems

- r. tend to give up easily
- s. are somewhat rigid and inflexible in their attitudes and opinions
- t. have great difficulty in making even minor decisions
- u. seem to enjoy their work and get pleasure from productive personal achievement
- v. tend to worry, to be irritable, and to feel anxious
- w. are described by others as moody
- x. may experience episodes of depression
- y. seem to lack energy
- z. do not have many interests

5) **T-Scores 58-64 (moderate elevation) are indicative of individuals who:**

- a. prefer to be alone or with a small group of friends
- b. have the ability to interact with others but generally prefer not to

6) Normal range: **T-Scores 40-57**

7) **T-Scores < 40 are indicative of persons who:**

- a. are sociable and extroverted
- b. are outgoing, gregarious, friendly, and talkative
- c. have a strong need to be around other people
- d. mix well at social gatherings
- e. are seen as intelligent, expressive, and verbally fluent
- f. are active, energetic, and vigorous
- g. are interested in power, status, and recognition
- h. seek out competitive situations
- i. have problems with impulse control and may act without considering the consequences of their actions
- j. are somewhat immature and self-indulgent
- k. may have superficial and insincere relationships with other people
- l. may be manipulative and opportunistic
- m. may arouse resentment and hostility in others

T > 75 Extreme social withdrawal/avoidance

T = 65---74 Introverted, depressed, guilty, slow personal tempo; lacks self--- confidence; lacks interests; submissive, compliant, emotionally over--- controlled

T= 55---64 Shy, timid; lacks self---confidence; reliable, dependable

T = 45---54 Average score, no interpretation

T < 45 Extroverted, gregarious, self---reliant, energetic, competitive, under---controlled, manipulative

Subscales

Si1 – Shyness/Self---Consciousness

Si2 – Social Avoidance

Si3 – Self/Other Alienation

Si1 - Shiness/self-consciousness - shy, uncomfortable with people very low - extroverted,

Si2 - Social avoidance - avoid groups

Si3 - Self/other alienation - low self-esteem, low self-confidence, indecisive, nervous

Very Low = extroverted, superficial and manipulative in rel-s.

Subscales for *Si*

Scale *O* is heterogeneous in item content and factorially complex. Graham, Schroeder, and Lilly (1971), for example, found six interpretable factors, but Ben-Porath et al. (1989) believed subscales based on these factors lacked internal consistency. The subscales also overlapped extensively and were difficult to interpret. Ben-Porath et al. developed three subscales for Scale *O* that obtained coefficient alpha estimates of .75 or greater among college men and women. Although these subscales have the advantage of high reliability and zero overlap, they account for only 39 of the 69 items on Scale *O*, or 57% of the total, whereas the previous Serkownek (1975) MMPI subscales accounted for 66 of the 70 Scale *O* items. The consequences for interpretation are considerable. Theoretically at least, a patient may achieve *T*-scores of 65 or more on both *Si1* and *Si2*, the subscales most highly saturated with the introversion dimension, and not exceed a *T*-score on Scale *O* of 50, provided that *Si3* is low. Conversely, *T*-scores of 70 or more on Scale *O* may be obtained without endorsement of any items on *Si1* or *Si2*. As an estimate of pure social introversion, *SOD* is to be preferred over Scale *O*.

Two broad content domains of Scale *O* have been identified as shyness and selfconsciousness,

the subjective aspect of introversion; and social avoidance, the objective or socially visible aspect of introversion (Nichols & Greene, 1995). Greene (2011) further validated these content domains by identifying the 15 scales from the Caldwell (2007b) clinical sample with the highest correlations with Scale 0. The two broad categories identified within these scales are shyness/self-consciousness (scales *Si1*, *SOD2*) and social avoidance/introversion (scales *Si2*, *SOD1*).

As described in the Scale 5 section of this chapter, Graham et al. (1971) factor analyzed the responses to Scale 0 from 422 psychiatric inpatients, outpatients, and normals. They identified seven Scale 0 factors, of which six were used by Serkownek (1975) to construct subscales for Scale 0. The seventh factor, Demographic Variables, was not used to construct a subscale. The Scale 0 subscales were named Inferiority-Personal Discomfort (*Si1*), Discomfort With Others (*Si2*), Staid-Personal Rigidity (*Si3*), Hypersensitivity (*Si4*), Distrust (*Si5*), and Physical-Somatic Concerns (*Si6*). As Greene (1991a) pointed out, clinicians can continue to use the Serkownek (1975) subscales on the MMPI-2 as only 1 item has been dropped from Scale 0, which reduced *Si2* from 14 to 13 items. Graham (1987) reported test-retest reliability coefficients for men and women (over a six-week interval) provided by Moreland (1985). Over all of the Serkownek subscales, the coefficients range from .68 to .89, with an average of .77 for men, and range from .63 to .87, with an average of .76 for women. Williams (1983) reported oneweek test-retest reliabilities for *Si* subscales averaging .84 for women and .68 for men. In a large-scale study, Foerstner (1986) investigated the interrelationships among the 63 MMPI subscales developed by Serkownek (1975), Harris and Lingoes (1955), Wiggins (1966), and Wiener and Harmon (1946). Nine hundred MMPIs from male and female psychiatric inpatients, chemical-dependent residents, and private practice outpatients were analyzed. Ten factors were identified that accounted for 75.5 percent of the total variance. *Si4* (Hypersensitivity) loaded on the first factor, Depression (.67), as did *Si1* (Inferiority-Personal Discomfort; .65) and *Si5* (Distrust; .44). *Si3* (Staid-Personal Rigidity) loaded negatively on the factor named Social Introversion. *Si1* also loaded on the third factor, Agitated Hostility (.64). *Si5* loaded on the factor Cynical Distrust (.63). It is clear from the data in Foerstner's investigation that Scale 0 (like Scale 5) is multifactorial and that maladjustment is a major component of the scale. A Scale 0 score, whether high or low, may be achieved by item endorsements affecting any of a

combination of at least six factors (Wong, 1984). In contrast to the non-pathological correlates for the Serkownek *Mf* subscales, the *Si* subscales, with the exception of *Si3*, appear pathology related.

Ben-Porath, Hostetler, Butcher, and Graham (1989) developed three new contenthomogeneous subscales for *Si* to replace the Serkownek subscales that are generally no longer used. They used a multistage approach involving a series of empirical and rational procedures. These subscales—named Shyness/Self-Consciousness (*Si1*), Social Avoidance (*Si2*), and Self-Other Alienation (*Si3*)—were developed with data provided by college students. Data analysis with this and the re-standardization sample demonstrated that these new measures combined to contribute to the assessment of nearly 90 percent of the variance of the full *Si* scale. Validation of these subscales was provided in the results of Sieber and Meyers (1992). These investigators compared results on the *Si* subscales against self-report measures of constructs that were believed to be differentially related to the three subscales. They stated that:

specifically, measures of self-esteem, public self-consciousness, social anxiety, and shyness were expected to correlate with *Si1*; measures of self-esteem, public selfconsciousness, social anxiety, and social avoidance were expected to correlate with *Si2*; finally, measures of self-esteem, alienation, anomia, loss of control, and personal and social identity were expected to correlate with *Si3*.

(Sieber & Meyers, 1992, p. 185)

These hypotheses were generally supported by the data. It appears that elevated *Si1* scores reflect shyness around others, uneasiness in social surroundings, and discomfort in unfamiliar situations. High scorers tend to lack social skills and feel disadvantaged when interacting with others, especially strangers. Low scorers are comfortable in social situations. High *Si2* scores appear to reflect an active avoidance of others, a dislike of group situations, and an aversion to social events. Low scorers are social joiners and enjoy group activities. High *Si3* scorers appear to have low self-esteem, a lack of interest in activities, low self-confidence, and to not feel in control of their life outcomes. The emphasis is on personal rather than social inadequacy, with a secondary theme of cynicism, hypersensitivity, and a sense of being at odds with others. In contrast, low scorers feel confident and are engaged with others.

In their investigation of the *Si* subscales, Ward and Perry (1998) found, as in previous

research, the three *Si* subscales accounted well for the variance in *Si* scores in clinical samples. *Si3* items were found to be less obvious indicators of social introversion as compared with *Si1* and *Si2* items; *Si3* appears to be more of a measure of the general maladjustment factor of the MMPI-2. Ward and Perry cautioned users of the *Si* subscales to recognize that *Si1* and *Si2* are purer measurements of the social introversion construct, and are not reflective of negative emotionality. In fact, they pointed out that the item content of *Si1* and *Si2* is virtually the same as that from the *SOD* content scale. Nichols (2011) suggested considering *SOD* (Social Discomfort) as a purer estimate of social introversion than Scale 0. He explains that while the *Si* subscales have the advantage of high reliability and zero overlap, they account for only 39 of the 69 items on Scale 0. *Si* lost one item in the revision of the MMPI-2; six items were modified to modernize idioms and usage of words, improve grammatical clarification, and simplify wording. There is a fairly even balance of True and False keyed items, with 36 keyed True, and 33 keyed False.

Scale 0 has proportionately fewer overlapping items than any other validity or clinical scale (Greene, 2000). Forty-two of the items on the scale overlap other scales, with 27 non-overlapping items. The *Pd* and *Mf* scales share the most items with *Si* (11 and 9 items, respectively). The *L* and *F* scales share no items with Scale 0. The highest net overlap with Scale 0 is found on Scales 2 and 7 with strong overlap on the following subscales: *D1* (seven items), *D5* (three items), *Hy1* (five items; negative), *Pd3* (five items; negative), and *Ma3* (three items; negative). *Si* also shares 18 items with *SOD*. Nichols (2011, p. 199) provided useful configural interpretive information for Scale 0 in relation to other scales based, in part, on the Caldwell (2007b) clinical data sample.

Among the basic clinical scales, Scale 0 is most highly correlated with Scales 7, 8, and 2, in that order. It is highly correlated with *SOD* at .89. The most important configural relationship of Scale 0 is with Scale 9, with which it correlates .14. In patients with Bipolar Disorder, these two scales often cross in the transition between depressed and manic states. Low 0 and high 9 are synergistic with respect to social hunger. When both Scales 9 and 0 are elevated, 0 tends to dominate, whereas Scale 9 features are confined to those suggested by *Ma-0*, *Ma2* and *Ma4*. When both are low, Scale 9 tends to be dominated by *Ma3* and *Ma-S*, which mostly blend in with and augment the low 0 characteristics.

It should be noted that, like Scale 5, Scale 0 uses linear, rather than uniform, T -scores. Introversion–extraversion is a normally distributed individual difference variable of high heritability (Scarr, 1969). Many researchers and clinicians believe strong constitutional and biological factors contribute to the introversion–extraversion dimension of personality (e.g. Eysenck, 1967; Meyer, 1983; Wakefield, Wood, Wallace, & Friedman, 1978). The stability of scores on this scale over time appear to reflect this biological and/or constitutional component. Extraverts have a need for stimulation or sensation-seeking, whereas introverts try to avoid stimulation, and there is a vast literature on the underlying neuro-cortical substrates for this phenomenon (e.g. Eysenck, 1967; Friedman, 1982). The generally high test–retest correlations support this contention. For psychiatric patients, the coefficients range from .80 to .88 for a one- to two-week interval between MMPI administrations, and from .63 to .64 for a one-year interval between tests (Dahlstrom et al., 1975). In Hunsley et al.'s (1988) largescale meta-analysis of MMPI reliability studies using a wide variety of populations conducted between 1970 and 1981, an average test–retest reliability of .86 for 16 studies with time intervals from one day to two years was reported. Test–retest reliability data were reported for the MMPI-2 scales over about a one-week interval (Butcher et al., 2001). Test–retest $\mathcal{S}/$ correlations were .93 for men and .92 for women, and were the highest reported for any of the validity or clinical scales.

The behavioral stability for $\mathcal{S}/$, although highly stable and persistent, does fluctuate for patients with bipolar disorder, where it is not unusual to see Scale 0 scores shift by 30 or more T -scores between manic and depressive states (Nichols, 2011).

In the Hunsley et al. (1988) meta-analysis of the MMPI, an average internal consistency of .81 across 41 studies was reported. The *Manual* (Butcher et al., 2001) reports internal consistency estimates (Cronbach coefficient alpha) of .82 and .84 for men and women, respectively.

The quality and type of interpersonal relations high and low scorers experience varies with their $\mathcal{S}/$ elevations as well as with other significant scores in the profile. Generally, Scale 0 reflects how comfortable an individual is around other people. High scores (introversion) reflect discomfort with others, whereas low scores (extraversion) reveal a preference for being with others. Nichols (2011, p. 203) provides an insightful overview of high Scale 0 scorers and how they experience their interpersonal world.

High Scale 0 scorers are uncomfortable with others but do not necessarily wish to be alone or uninvolved. They form relationships slowly and deliberately, often after an initial period of considerable hesitancy and awkwardness. Once formed, however, these relationships may be highly stable, loyal, and intimate. These patients may be particularly uncomfortable dealing with members of the opposite gender, owing to deficits in heterosexual social skills that, in turn, are caused by their own shyness and past avoidance of situations (e.g. school dances) within which such skills are typically learned. In relatively close social interaction, these patients are peaceable and avoid conflict or unpleasantness. Even when safeguards are strong, they are quick to make concessions or submit, rather than expose themselves to the stimulation that comes with conflict, judging their skills as inadequate to its management. Resistance, if any, tends to be passive, and these patients may find fault with their own attitudes and conduct, or even fall into self-criticism or selfdeprecation to prevent or abort confrontation.

It is important to examine other clinical scales when Scale 0 is high or low because Scale 0 can operate as an activator or inhibitor for certain behaviors. When elevated in combination with other scales, Scale 0 is most often associated with anxiety and depressive disorders, but is not uncommon in schizophrenia. For example, a high Scale 8 score will indicate more social isolation and communication problems when Scale 0 is also elevated. When Scale 7 is elevated, look for anxious, insecure, ruminative individuals who dread social attention and may exhibit social phobia. A very low Scale 0 score will accentuate the impulsivity often seen in high Scale 4 scorers and indicate a superficiality and shallowness in relationships. When $\mathcal{S}i$ is elevated with a prominent Scale 4 score, individuals are seen as sour, caustic, and uncommunicative (Levak et al., 2011). When Scale 2, *DEP*, or low Positive Emotion (*RC2*) are elevated with $\mathcal{S}i$, consider the possibility of a long-term characterologically depressed, pessimistic, and defensively sour individual. Individuals with impoverished or compromised social relations, as often seen in schizoid, schizotypal, and avoidant personality disorders, tend to elevate Scale 0. Lewak et al. (1990, p. 273) stated that elevated $\mathcal{S}i$ scores may reflect a childhood characterized by an absence of warmth and physical contact from others. Elevated scores suggest that these people have extinguished their feeling response to physical touch and affection. They suffer from a form of “affect

hunger” and yet, they feel conflicted about close, intimate relationships.

Low $\mathcal{S}/$ scores reflect more than just social extraversion. Low scores ($T < 40$) suggest a drive toward social interaction, sometimes, but not always, out of insecurity. “Extreme low scores may reflect not only an insatiable need to be in the spotlight but also a low level of socially acceptable embarrassment in the face of obvious self-serving and selfaggrandizing behavior” (Levak et al., 2011, p. 358).

Hathaway and Meehl (1952) examined the descriptions of high normal $\mathcal{S}/$ scorers.

Men were described by their acquaintances with only one typical adjective, modest.

Dahlstrom et al. (1975) suggested that perhaps the introverted personality style of these men made it difficult for others to get to know them and, therefore, to characterize them more fully. In contrast, normal women scoring high on $\mathcal{S}/$ were described as modest, serious, shy, self-effacing, and sensitive. They showed emotional warmth and had home and family interests, but did not seek out social contacts and satisfaction. Dahlstrom et al. made the important point that the personality styles of these individuals appear to reflect the basic preference for a style of life in keeping with their emotional needs, rather than individuals who are inhibited or thwarted in their efforts to have broader social contacts.

Dahlstrom et al. (1972) also presented the research descriptions of high- and lowscoring men on $\mathcal{S}/$ provided by Gough et al. (1955). Both high and low $\mathcal{S}/$ scorers are described in more unfavorable, maladjusted, terms than in the earlier Hathaway and Meehl (1952, as cited in Dahlstrom et al., 1972) depiction of the introvert. Quoting Dahlstrom et al. (1972, pp. 227–228):

The high 0 men were described as slow in personal tempo, stereotyped, lacking originality in approach to problems. The implication seems to be that these men showed such qualities as part of a general insecurity. They were also described as unable to make decisions without vacillation, hesitation, or delay. They were seen as rigid and inflexible in thought and action, as overly controlled and inhibited, and as lacking confidence in their own abilities. They were conforming and followed prescribed methods in the things they did. They became fussy and pedantic in even minor matters.

In their relations with others, they were seen as lacking poise and social presence, as becoming rattled and upset in a social situation. Perhaps as a consequence,

these men were rated as cold and distant. They were not affected in this aloofness, however, but appeared free of pretense and conscientious and dependable in their responsibilities. They seemed to derive personal reward and pleasure from their work and placed a high value on productive achievement for its own sake.

Toward authority, these men were submissive, compliant, and overly accepting. They tended to sidestep as a way of handling troublesome situations. They either made concessions to avoid unpleasantness or passively resisted pressures by not getting involved in things. They were generally permissive and accepting, however, in their relations with others, respecting other people, and not making judgments. As a result, these high 0 men kept out of trouble and showed socially appropriate behavior. They get along well in the world as it is.

Low-scoring men (extraverts) in the normal group examined by Hathaway and Meehl (as cited in Dahlstrom et al., 1972) were described as versatile and sociable, whereas low-scoring women, also described as mixing well with others, were also seen as enthusiastic, talkative, assertive, and adventurous. The Gough et al. (1955) male low scorers were seen as expressive and colorful; they were also described as ostentatious and exhibitionistic. They ambitiously focused on success as a means for achieving status and power. Competitive and vigorous, they were dominant in relation to others, and could easily stimulate hostility and resentment around them. They could also be opportunistic in that they viewed others only in terms of what they could get from them, rather than being sensitive to their feelings. Self-indulgent and unable to delay gratification, they were often impulsive, acting without sufficient deliberation, which likely led to their being seen as immature.

Shyness/Self-Consciousness (Si1)

T-Scores > 65 are indicative of individuals who:

1. are shy around others, easily embarrassed, ill at ease in social settings, and uncomfortable in new situations

T-Scores < 40 are indicative of individuals who:

1. do not feel shy or embarrassed around others and feel at ease in social settings

Si1 (Shyness/Self-Consciousness—14 items): These items reflect the subjective aspects of introversion: bashfulness, feelings of social awkwardness and inadequacy, and fears of embarrassment. Such feelings are likely to be acute in new and unfamiliar situations. High scorers tend to be socially timid and quick to feel inept and conspicuous, the focus of disconcerting attention. They tend to lack social skills, and feel disadvantaged when interacting with others, especially strangers. *Si1* overlaps *SOD* by 10 items, 7 on *SOD2*. Low scorers are socially intrepid and are comfortable being highly visible in social situations.

Social Avoidance (*Si2*)

T-Scores > 65 are indicative of individuals who:

1. have a great dislike and avoidance of group activities and being in crowds
2. avoid contact with other people

T-Scores < 40 are indicative of individuals who:

1. do not dislike or avoid group activities and crowds

Si2 (Social Avoidance—8 items): This subscale reflects the objective aspects of introversion. It is more behavioral in its focus and emotionally more neutral. *Si2* overlaps *SOD* by eight items, all on *SOD1*. The items admit the dislike and active avoidance of crowds, parties, dances, and social gatherings and, when these cannot be avoided, a preference for remaining on the periphery and uninvolved. Low scorers like to join in with others for social activity; they like being where the action is. Occasionally, a low score on *Si2* will be seen with a high score on *Si1*, suggesting a highly self-conscious person who likes to “get lost in the crowd.”

Alienation—Self and Others (*Si3*)

T-Scores > 65 are indicative of individuals who:

1. have low self-esteem and self-confidence, are self-critical, question their own judgment, and feel incapable of determining their own fate
2. are nervous, fearful, and indecisive

3. are suspicious of others

T-Scores < 40 are indicative of individuals who:

1. are confident in themselves and their abilities and feel as if they have a hand in determining their own fate

2. believe in the good intentions of others.

Si3 (Self / Other Alienation—17 items): This set of items reflects the neuroticism component of Scale 0. The emphasis is on personal rather than social inadequacy, with a secondary theme of cynicism, hypersensitivity, and a sense of being at odds with others. None of the items overlap *SOD*. Many of the items suggest implicit comparisons of how the individual measures up against others. These disparate threads come together as a general inability to function competently in social situations; forgetfulness, irritability, distraction, self-conscious misery, a lack of confidence, or the way other people are will prevent the individual from performing effectively. Scores on this subscale are suppressed by *K*.

CodeTypes

Interpreting the Basic Scales

1) Use High Point Pairs

- find the 2 scales with the highest T-Scores and interpret the combination
 - have to be above 65
- many books list interpretative paragraphs for high point pairs
 - Groth-Marnat
 - Gardner
- Remember, these are generalizations about the typical individual who scores this way. You will need to tailor the paragraphs to fit your individual client.
 - based on probability statements; may or may not apply to a single client
- you should also interpret the individual scales, but the combining into code types yields some unique interpretive information

- when multiple code types are interpreted in a single profile, the highest two point pair receives more weight than any lower pairs if there are any contradictions
- if there are three or more scales above 65 and within a few T points of each other, divide the profile into as many two-point pairs as possible and interpret all of the pairs
- following are the top 22 most frequent high point pairs and the interpretations for each pair

o Code---type groups are more homogeneous

- Greater likelihood that descriptors will fit individual with the code type
- More focused descriptors

o Highest clinical scales in a profile

- High---point codes/One---point code types; highest clinical scale in profile
- Two---point code types; two highest clinical scales in profile
- Three---point code types; three highest clinical scales in profile

o Excluding scales

- Do not include scales 5 and 0 in determining code types. These scales are different in nature from the other eight clinical scales.
- Most previous code---type research has not included them.

o Order of scales

- Except when interpretive materials specifically indicate otherwise, order of scales in two--- and three---point code types is not important (e.g., 13 code and 31 code have same interpretation).

o Definition

- Interpret only defined code types ----- at least 5 T---score points between lowest scale in code-type and next highest clinical scale in profile (excluding 5 and 0).
- For profiles that do not have defined code types, interpretation should focus on individual scales.

o Elevation

- When scales in defined code types are elevated ($T > 65$), include both symptoms and personality descriptors in interpretation.
- When scales in defined code types are not elevated ($T < 65$), include personality descriptors but not Symptoms in interpretation.

Basic

Diagnosis

Psychosis 46% Schizophrenic/paranoid

Psychoneurosis 28% Depressive

Personality disorder 20% Trait/aggressive

Brain syndrome 6% Chronic

Personality Description

It seems clear that the characteristic expression of the average patient's unhappiness is via depressive mood, despondency, and feelings of hopelessness.

This clinical assessment is in accord with the frequent elevation of scale 2 for both inpatients and outpatients. A correlate of this depression is the introjective disposition of the patient, that is, the tendency to turn blame and punishment inward against the self rather than outward against others. It may also be that the complaints of weakness and easy fatigability are somatic counterparts of subjective depression. Closely comparable in ratings by clinicians are the propensity for persistent worrying and a tendency to overreact to what is perceived as threat.

Unfortunately, those things that others perceive as mere irritants are seen as dangerous by the patient; minor discomforts are reacted to as emergencies. A variety of fears and phobias are present. Anxious, tense, high-strung, and jumpy are adjectives characteristically applied to this patient, who has difficulty sleeping as well. One of the most pervasive aspects of the behavior is lack of modulation—an inability to maintain an emotional balance.

Thus, it may be said that the defenses which ordinarily relieve psychological distress are not adequately functioning. The average patient seems basically insecure and has exaggerated needs for attention and affection. These needs, the inner conflicts about dependency, and the fear of emotional involvement with others, lead the patient to keep others at a distance and to make close personal friendships very difficult. The ratings also indicate distrust of people, doubt about the motivations of others, and sensitivity to anything that can be construed as a demand. It follows that a person with these conflicts would also entertain sexual conflicts. The average patient is considered to be more than normally ruminative and obsessional and to display stereotyped rather than flexible approaches to the solution of problems. Resentment and irritability are manifested, though at what might be characterized as a moderate level. The average patient is a hospitalized 40 year old. Her personal history places her as a middle child in a disrupted home. Her academic history is about average and she has a high school education. Although withdrawn, the average patient dated frequently and married at age 20, with parental consent. The areas most affected by the patient's

disturbance appear to be "personality" and "home." There is generally only small improvement with treatment, which tends to be "psychotherapy only," and the prognosis is poor.

Spike 1

Scale 1: Hypochondriasis (HS)

Descriptors

Complaints

Physical illness, pain, fatigue, irritability, low sex drive, fears of body damage and decline

Thoughts

Fear of illness and death, rigid, lacking insight, critical

Emotions

Unhappy, pessimistic, unenthusiastic, expressing anger indirectly, tense

Traits and Behaviors

Avoid taking risks, self-centered, demanding, stubborn, complaining, controlling, manipulative, dependent, lacking drive

(Levak, Siegel, Nichols, & Stolberg, 2011)

Therapist's Notes

Individuals with normal Scale 1 elevations are health conscious and mindful of their physical well-being. They ensure that any illnesses are well taken care of, avoid health risks, and are mindful of the dangers associated with physical illness. As scores increase, Scale 1 elevations are associated with a profound fear of bodily harm, physical illness, pain, and death. Individuals with elevations on Scale 1 experience physical sensations as frightening because they fear that they may signal the onset of some disease or physical breakdown. Psychological stress leads to an increase in physical symptoms, which then becomes a consuming focus. They are often seen as lacking in insight

because internal conflicts and external stressors tend to be reduced to physical preoccupations. Their somatic focus tends to shift and change and be shaped by the medical personnel whose attention they frequently seek. Individuals with elevations on Scale 1 often have few other complaints except those centered on physical illness and infirmity. They learn to be persevering and stubborn about seeking medical help, and their symptoms can be shaped and aggravated by their encounters with the medical system. They tend to “doctor shop” depending on their current somatic focus; these patients are often referred to different medical specialists who run numerous medical tests without finding a specific cause for their somatic complaints. In other situations, years of repression, inhibition, and denial lead to actual physical deterioration. However, their level of preoccupation and concern, even in the presence of real physical illness, is often exaggerated, as it provides a focus for their psychological conflicts. In some cases, neurological conditions can cause an elevation on Scale 1, but typically there is some psychological component whenever Scale 1 is above a T-score of 65. People with Scale 1 elevations tend to be seen as quite dependent and demanding, and they become skilled at manipulating others to take care of them. Apart from their physical concerns, they can appear almost emotionally bland and even cheerful, reflecting their denial and a lack of psychological insight (Brower, 1947). The hypothesis associated with Scale 1 elevations is that these clients are terrified of bodily damage. They experience little pleasure from their bodies, living with a sense of dread that, at any moment, physical symptoms will increase in severity or that they will be plagued by some new physical infirmity. Female clients with high scores on Scale 1 reported histories of physical abuse and suicide attempts. Both male and female clients reported symptoms of anxiety.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Lifestyle and Family Background

Clients with this profile may have experienced a recent physical trauma or illness that has induced a state of panic and preoccupation with physical symptoms. In other cases, somatic preoccupation is associated with early childhood illnesses, either in the clients or in significant family members. They learned from an early age to fear physical infirmity and may have experienced significant losses associated with illness. In other cases, these clients may have experienced a recent physical trauma, which has stimulated their panic about physical infirmity. A recent trauma in the absence of a history of somatic preoccupations would suggest a reactive disorder. Psychologists working with disability claimants may have difficulty determining the contribution of recent traumatic events versus that of longstanding personality style to Scale 1 elevations. A comprehensive history will help in determining the relative strength of these factors and their effects on somatic preoccupation.

(Levak, Siegel, Nichols, & Stolberg, 2011)

A high score in isolation ($T > 65$), known as the Spike 1 profile, reflects a person preoccupied with numerous physical complaints, fears, and anxieties about physical illness, injury, or decline. These individuals generally lack joy, see themselves as physically infirm, and view their bodies as sources of pain, fear, and discomfort, rather than as sources of physical pleasure. Others describe them as demanding, complaining, and egocentric, perhaps because their complaints impose demands on others. Generally, they have difficulty openly expressing anger, which tends instead to be expressed symbolically through their symptoms. Others describe them as stubborn, pessimistic, negative, and lacking in drive. Although individuals with Scale 3 elevations also exhibit numerous physical complaints, they are different from individuals with high scores on Scale 1; they are more cheerful, even blasé and denying as they complain of pain. When Scale 1 is elevated, the individual may suffer from actual physical infirmities, but their panic around these infirmities and their focus on them as the main cause of their distress differentiates them from other ill people who take a more realistic view of their symptoms. For high Scale 1 individuals, psychological conflicts and distress are expressed through the prism of physical complaints, some of which may be organic. For example, Carol, a 43-year-old, well-educated Caucasian with a Spike 1 profile, presents as constantly panicked around vague physical symptoms. After a strenuous yoga session, she experiences shoulder pain with numbness in her fingertips. She researches the symptoms on the Internet and decides she may have multiple sclerosis. Upon experiencing intense panic and fantasizing about her death and the loss of seeing her children grow up, she begins to experience tingling in her leg. Further research convinces her she has lupus and her panic increases. Carol cannot entertain the exploration of other stresses in her life because she is focused on finding the right doctors to diagnose what she is convinced is a terminal disorder. Certain demonstrable neurological disorders can elevate Scale 1 into this range. However, it is not clear how much elevation is due to psychological factors and how much is due to neurological factors. Even in individuals with bona fide physical problems, these elevations predict a pessimistic and fearful attitude about health and a fragile trust in caregivers. Their symptoms and hypochondriacal preoccupations typically are longstanding and resistant to change. Although stress can aggravate their physical symptoms, their complaints are generally not a reaction to immediate stress—though they may be aggravated by it—but rather the result of a longstanding personality style in dealing with stress. As clients, these people can be challenging because they become easily discouraged and do not fully comply or follow through with treatment suggestions. Readily doubting a particular diagnosis and highly suggestible, they “doctor shop,” their anxieties shaped by the new doctor’s specialty. Although elevations on Scale 1 increase with age, they do not reach an elevation above T -65 purely due to age. When Scale 1 is above T -75, somatic concerns dominate the individual’s life. Moderately high scorers (T -55–65) may be reacting to a bona fide physical disorder; although, in such cases, they are more likely to have an accompanying elevation on Scale 2. Some physical illnesses (e.g. Lyme disease) have physical

symptoms that can elevate Scale 1 into this range. Even in this moderate range, there is a tendency to be somewhat pessimistic about health, the possibility of attaining happiness, to somatize under stress, and to be somewhat repressed and inhibited in expressing negative affects. Moderately low scores on this scale (T -35–45) suggest a person who is not overly concerned about bodily functioning and who is generally effective in daily living (if no other scales are elevated above T -60). Such individuals are seen as resilient, alert, and energetic.

Though there is little empirical data on very low scores ($T < 35$), we hypothesize that they can be obtained for a number of reasons. The individual may be reacting to a family member who used hypochondriacal illnesses in a manipulative way and now is overreacting by rejecting even normal aches and pains; or the individual may be extremely health conscious and takes pride in their health to the point of ignoring aches, pains, or illnesses until the illness is quite severe. Very low scores on Scale 1 may be meaningful in elevated depression profiles (e.g. 278 codes), where the low Scale 1 score may reflect disinterest in one's physical well-being to the point of passive resignation and indifference to one's body.

Presenting Problem

Concern about one's health and physical integrity, with a need for a visible sign or internally experienced sensation (e.g., pain, weakness) to be placed in a medical context. The concern may focus on disease, disability, physical damage, or on the implications of one's symptoms for deterioration, morbidity, or mortality.

Insomnia or other sleep difficulties are often mentioned. The presenting problem is characteristically difficult to localize and classify, and the physical complaints are often accompanied by a detailed narrative of the patient's medical history that may include an extensive technical vocabulary of symptoms, diseases, and so forth (the hypochondriac's "organ recital") and diagnostic and treatment procedures that have brought no relief. There may be considerable and bitter criticism of previous physicians ("quacks," "charlatans," "pill-pushers") for their incompetence, greed, or lack of care ("just in it for the money"). Earlier doctors missed or bungled the diagnosis, failed to order the correct lab test, gave medication that didn't help, made the problem worse, or produced intolerable side effects. Among psychiatric patients, the symptoms of concern are much less stable over time unless they are linked to delusional ideation. Cases of pure hypochondriasis are now virtually never seen in psychiatric hospital settings, but patients who are hypochondriacal on a comorbid basis are not especially uncommon.

Symptomatic Pattern

These patients tend to be sensitized to interior somatic sensations or to the potentially dire health implications of visible signs. Although not typically depressed or anxious, high scorers tend to be cheerless, dissatisfied, and somewhat pessimistic or cynical in their outlook. Anxiety, when present, is apt to take the specific form of

nervousness. Patients are sluggish and unenthusiastic, lacking in drive and ambition, and are difficult to excite. Cognitively, they tend to be rather narrow, unimaginative, uncreative, conventional, and bound by habits and routines. Despite their self-centeredness, they are not characteristically self-indulgent. To the contrary, they are cautious and self-denying in many areas and view many pleasures as frivolous. Their dealings with others outside the family are distant but responsible and conscientious. They are generally polite, sincere, and considerate, observe rules and regulations (albeit somewhat resentfully at times), and do not act out in antisocial ways. Incapacity is rare. These patients are usually able to function but suffer a reduced level of efficiency.

Interpersonal Relations

These patients tend to form long-term, dependent attachments of an extractive kind onto another person, typically a spouse. Their relations with others tend to be limited, utilitarian, and controlling. They place excessively high expectations and demands on intimates and become sullen or whiny when others fail to provide them with adequate levels of attention, consideration, or service. At the same time, they are emotionally reserved and stingy where others are concerned and often appear stubborn, bitter, self-centered, selfish, un giving, ungrateful, and difficult to please. Their anger (especially hostility) tends to be expressed indirectly through dissatisfaction, demandingness, and controllingness. Somatic symptoms and disabilities can also be used manipulatively to intimidate others, instill guilt and a heightened sense of obligation, or both. Over time their behavior pattern creates an accumulation of resentment in others who may, in turn, meet the person's needs more sparingly, grudgingly, or both. Nevertheless, their marriages tend to be stable. Carson (1969) noted that these patients "appear readily to adopt a paranoid posture when pressured" (p. 284).

Behavioral Stability

This pattern can be extraordinarily stable over time. Scale 1 is considered to be one of the character scales of the MMPI-2.

Defenses

Displacement of depression, anxiety (including anxiety about having a serious or life-threatening illness), or dependency onto physical symptoms, illness, or disability. Rationalization (e.g., for failure to achieve). Conflicts; denial of other problems. Projection of selfishness and self-centeredness. Somatization may afford a way out of undesirable activities and situations such as social or sexual interaction. Finally, counterphobic denial of illness or injury may be seen with low scores.

History

Look for multiple previous medical contacts, physical examinations, laboratory tests, invasive diagnostic procedures (laparoscopies, spinal taps, etc.), treatments, and surgeries. The patient may have had a great many medical contacts, both recently and over many years (“doctor shopping”) without relief.

These patients often come from underprivileged backgrounds in which the family of origin was impoverished or subject to economic instability either because of external factors, such as layoffs and periods of unemployment, or internal factors, such as an absent or alcoholic father. Often the family provided an environment conducive to the learning of illness behavior either indirectly—through the illness or death of a parent, sibling, or other close relative, or through the hypochondriacal modeling of an important adult—or directly, through the patient’s own experience of frequent illness, life-threatening disease, or catastrophic accident. Intelligence and educational attainment are generally lower than average, although occupational attainment may be fair (e.g., skilled tradesperson).

Diagnostic Considerations

Diagnoses tend to be among the Somatoform Disorders, such as Somatization Disorder or Hypochondriasis, but comorbidities may be extensive, especially substance abuse (often of alcohol, prescription drugs, or both for pain or sleep) or depression.

Treatment Considerations

In a medical context these patients are best treated conservatively and without extensive workups and diagnostic tests. Issues of medication should be handled carefully, because these patients are quick to experience side effects due to their somatic focus and sensitivity to internal sensations. Medications need to be monitored closely to ensure that they are being consumed according to prescription. There is some potential for the development of abuse. These patients are often referred to psychiatrists or psychologists after their primary physicians have become exasperated with them, deciding that they are not real patients, but “crocks.” Consequently, patients are likely to view the initial contact skeptically, as being unjustified and possibly demeaning. In particular, they are apt to be overwhelmingly resistant to any idea of psychological causation, which the hypochondriac is likely to interpret as meaning that the problem is “all in my head.” Not to be discounted is the possibility that the patient has encountered real scorn in contacts with previous doctors, and this, and the psychologist’s understanding of it, can often create an initial foothold for treatment.

Several initial approaches may be effective but all tend to require attention, sympathy, and support. Time, appointments, and attentive listening help the clinician assess general attitudes toward illness, mortality, and relationships, both in their substantive dimensions and through their revelation in the patient’s use of language.

Many of these patients often lack verbal fluency and a suitable vocabulary (alexithymia) for conventional, feeling/emotionality focused, psychotherapeutic efforts, and thus may feel significantly disadvantaged in any context in which the primary medium is talk. The therapist's ability initially to mirror the patient's language can be helpful. Reassurance tends to be counterproductive as patients view it as oppositional; moreover, it was likely attempted in the past without benefit, and its use will tend to identify the therapist with earlier doctors who were unable to help. These patients tend to draw reassurance from the availability of the therapist and the continuity of relationship and support. They also tend to gain confidence from the therapist's focus on the patient's coping problems resulting from anxiety, fear, misunderstandings, and so on, and from a deemphasis on their actual health status.

In addition to establishing therapeutic rapport, an initial goal of treatment is to achieve a shift from somatic to interpersonal language; the use of metaphors such as tension and stress may be useful here. The hypochondriac's language often conspicuously lacks references to family, friends, and other relationships. Stress and tension can serve as bridge metaphors that provide a path from initial discussions of tension as a cause of pain and discomfort to later explorations of the effects of the patient's stress on the spouse and others. Initial feelings of anger, frustration, and bitterness should over time give way to fear, disappointment, and helplessness. Where present, this transition can be a sign of progress in the treatment. Cognitive interventions may center on the patient's persistent tendency to construe innocuous somatic sensations as signs of illness and on the anxiety stimulated by such misinterpretations. Directive interventions generally are best offered pessimistically, with ample permission for rejection. For example, "I doubt that this will be much help, but I've seen it work before when I didn't expect to. You could give it a try if you want." Exercise and behavioral treatments such as relaxation, biofeedback, hypnosis, and chronic pain programs can be helpful for some patients, but treatment for patients with substantial hypochondriacal histories tends to be long term.

Some of the foregoing considerations apply poorly to patients with somatization patterns of recent or traumatic onset. Such patients can often be treated much more aggressively and may respond well to reassurance, explanations, and strategies for reducing or coping with stress (Kellner, 1991).

Low Scores

Low Scale *I* scores are achieved in two fundamentally different ways: first, by a very low raw score on *I* and an average score on *K*, second by the endorsement of few items on both *I* and *K*. The first is preferred and suggests an overall sense of comfort in one's own skin. Freedom from somatic ailments; greater initiative in physical and social activity; positive enjoyment of embodiment in general; a sense of pleasure in exercise, exertion, and activity; and an

ability to accept challenges and opportunities without trepidation are all consistent with this pattern. There may be a lack of attention given to matters of health and safety, with the assumption of imprudent risk-taking in physical activity. In the second pattern, the freedom from somatic ailments is joined with the self-criticism, dissatisfaction, inefficiency, cynicism, and social awkwardness of low *K*. There may be neglect of illness or injury until such problems become worse and more debilitating.

- o Dissatisfaction and concerns about health and physical functioning, but usually with limited emotional distress. Look for compromised efficiency in work and reduced enjoyment of leisure and recreation.

- o Overly favorable in self-report, portraying him- or herself as morally upright; free of emotional and cognitive problems; and confident, independent, responsible, outgoing, and identified with family.

High-Point Vs When scale 5 is omitted in the coding system and when *K* corrections are routinely applied, scale 1 is one of the most frequent high points in the profiles of both normal and psychiatric groups. The data in Appendix M and in the Atlas also indicate that scale 1 is typically prominent in the code and is infrequently a low point in the code except in those with a leading 9. Scale 1 peaks increase in frequency with age and are especially prominent in patients consulting a physician (see Appendix M). This scale plays an important role in the patterning of the neurotic triad and furnishes useful interpretative data, either to characterize the current adjustment of the subject or to qualify the inferences drawn from other profile characteristics. The *K* correction applied to this scale can make important differences not only in the absolute level of the score on scale 1, but also in the configuration of the profile. Gough, McKee, and Yandell, as reported in Chapter 6, found different correlates of this scale with and without the correction. This scale is more frequently the low point in the profile when *K* corrections are not employed. Guthrie found that medical patients with peak scores on scale 1 presented a wide variety of symptoms and complaints. Although many of the men presented epigastric symptoms, neither respiratory nor circulatory difficulties were well represented. There was typically little manifest anxiety in their initial behavior, but when present it indicated a better response to treatment than would otherwise be the case. The group did not typically show any evidence of incapacity of major proportions, even though many of the MMPI profiles were markedly elevated. Rather, these patients appeared to be carrying on with reduced efficiency. Their symptoms appeared to be part of a long-standing inadequacy and ineffectualness rather than a solution to some pressing problem of the moment. There was little evidence of psychopathic acting out in this group. They usually responded well on a short-term basis; but they made many return visits, usually with the same symptoms, or with new problems of equal severity. In college groups peaks on 1 are quite rare. Neither Black nor Mello and Guthrie found enough cases to develop any stable basis for descriptions. Drake noted that counselees with "home conflicts" were found when either

scale 4 or scale 5 was coded low in conjunction with a peak on scale 1.

(Dahlstrom, Welsh, & Dahlstrom, 1979)

Modifying Scales

- The items on Scale 1 are face valid as are the items on Health Concerns (HEA) and Somatic Complaints (RC1) which are typically also elevated. Usually, Gastrointestinal Symptoms (HEA1), Neurological Symptoms (HEA2), and General Health Concerns (HEA3) are all elevated, though in some cases the complaints are focused on a specific set of somatic symptoms.
- If the Depression (DEP) and Anxiety (ANX) scales are elevated, clients will express depression, fears, and anxieties about their physical condition.
- If Anger (ANG) is elevated, individuals are typically demanding and irritable due to physical concerns.
- If Fears (FRS) is elevated, fears and phobias in addition to the somatic concerns are likely. A generalized anxiety disorder may be present.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Female

Low 5 Headaches.

o **Check:** *HEA, RC1, HEA1, HEA2, HEA3, D3, Dr3, Hy4, Sc6.*

>80 - somatic delusions

>65 - somatic concerns, vague and epigastric somatic complaints, somatization, pessimism, psychologically naive, narcissism, immaturity, rigidity

58-64 - lesser degree of the above or an actual disorder

38-45 - adequately adjusted, insightful, may appear moralistic and interpersonally detached

<38 - deinvested in their bodies, high risk behaviors

TREATMENT

Assertiveness training and education around how to deal with anger often are appropriate with this code pattern.

Have the individual keep a diary of when physical symptoms seem to increase in severity and look for links between emotional stresses and physical discomfort. Supportive, non-confrontive therapies appear to work best. Look for

childhood experiences of early losses or frightening illnesses in the individual or close family members and/or a family style of discouraging the expression of negative affect that may have conditioned these individuals into developing physical responses to stress.

o **Treatment:** May be resistant to insight and psychological approaches.

Therapy and Therapeutic Pitfalls

Our hypothesis is that a somatic preoccupation can be seen as an adaptive response to actual or feared experiences of bodily damage in the clients or a close family member. The goal of therapy would be to decondition the traumatic events through various cognitive-behavioral techniques. Reassure them that their somatic worries will be taken seriously as they have had some negative experiences with the medical system, telling them their worries are “in their head.” Clients with Scale 1 elevations are very focused on physical symptoms, so they are vulnerable to becoming anxious and preoccupied about side effects and the effectiveness of medications. Antianxiety medications are useful in providing them temporary relief as is helping them understand that anxiety is a significant component of their symptoms. They are highly suggestible, so changes in physical sensation tend to be upsetting to them, hypnosis can panic them; relaxation training can be used but only after the clients’ panic has been stabilized. Attempts to reassure clients with this profile and to shift their focus of attention away from physical symptoms to other conflicts in their lives tend to be met with resistance. Not focusing on their physical problems creates anxiety in them that others do not understand their physical infirmity and increases their fear that they will be overwhelmed by pain and physical decline and have no one to turn to. Developing a therapeutic alliance involves initially “going with the resistance”: helping them organize their medical treatment to avoid repeating numerous medical tests and to help rule out various disorders. Cognitive-behavioral techniques to alleviate anxiety have received empirical support (Gould, Otto, Pollack, & Yap, 1997; Stewart & Chambless, 2009) and can be used in conjunction with psychoeducation to inform them about how anxiety in their lives may be related to an increase in physical symptoms. In some cases where there has been physical trauma, stress inoculation training, and exposure therapy can help build coping skills (Doane, Feeny, & Zoellner, 2010; Lee, Gavriel, Drummond, Richards, & Greenwald, 2002).

In the presence of early childhood illnesses in clients or their families, the reengagement of early traumas followed by relaxation training and emotional catharsis can be useful for long-term healing. The goal of long-term therapy is to decouple the link between stress and immediate panic around physical symptoms. Help the clients realize that increased physical symptoms are associated with inner conflicts and anxieties. It is important to validate their physical symptoms as real but also to identify which stressors lead to increases in physical symptoms and to help develop better coping strategies. Gestalt therapies can be useful. Getting clients to have their symptoms “do the

talking” could provide a concrete, effective way to express repressed emotions. For example, someone with severe and constant stomach upsets could be asked, “If your stomach had a voice, what would it say right now?” In another gestalt exercise, clients might be asked, “If you could paint a picture of what your stomach felt like right now, what would the picture look like?”

Psychologists working for insurance companies in disability claims may have an incentive to suggest that clients with Scale 1 elevations are malingering and that their physical complaints are psychological. Prolonged psychological stress can lead to physical breakdown in some people, and untangling the contribution of psychological and organic factors in their contribution to Scale 1 elevations is difficult.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Treatment and Self-Help Suggestions

1. Keep a diary of your physical symptoms to see if they increase when you are stressed or if they change over the course of a day. See if you can link the change in your physical symptoms to anything that happens during the day or to your inner feelings. While your physical symptoms are real, they may be aggravated by stress. Understanding how stress aggravates your physical condition could help you in learning how to control them.
 2. Even though you may resist physical activity and you may be unable to be very active, some form of daily exercise is important in helping you heal. Together with your medical doctor, create a program of acceptable physical exercises that can help deal with stress.
 3. Learn to visualize relaxing and peaceful moments and situations so that you can relax your whole body on a daily basis. Tension can aggravate any kind of physical ailment.
 4. If you are able to stretch, do some of kind of yoga that doesn't increase your pain. Or meditate; these can all help promote physical and emotional healing.
 5. Fill out the “Daily Hassles and Stress” form (<http://www.scribd.com/doc/7156530/Daily-Hassles-and-Stress-Scale>). This can help you identify sources of stress in your life. You and your therapist can then address specific “hassles” (e.g., “Unwanted interruptions at work,” or “Not enough leisure time”) that may contribute to your symptoms.¹
 6. Talk to your therapist about biofeedback (a type of therapy used to help control physical responses to stress). By using equipment that gives you visual feedback, you receive information about tensing or relaxing various areas of your body, which, with practice, helps to control pain.
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1 Clients who had more daily hassles as reported on the “Daily Hassles” form experienced more physiological and psychological health problems (Bottos & Dewey, 2004; DeLongis, Coyne, Dakof, Folkman, & Lazarus, 1982). The “Daily Hassles and Stress” form can be found on the Web site mentioned above (Kohn & MacDonald, 1992).

(Levak, Siegel, Nichols, & Stolberg, 2011)

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you spend a lot of time thinking about your health, how to maintain it, avoid becoming ill, and correctly diagnosing some of your symptoms. Your health may be a source of constant worry for you and you may experience numerous vague and shifting physical symptoms that really frighten you. When stresses accumulate, your physical symptoms may increase and that increases your fear that something is very wrong with you and that nobody has diagnosed you correctly. You are not a very aggressive person and people may annoy you because they push you or try to control you. You, or somebody close to you, may have experienced physical infirmities that frightened you, leading to your adaptive response of constantly being on edge to anticipate and prevent physical problems. Keep a diary of when your symptoms become more severe and see if you can link them to stress. Work with your therapist on being more assertive and take a mindfulness class to learn how to recognize some of your more subtle emotions.

Feedback Statements—Elevated Profiles (T-Score > 65)

Strengths

Your profile reveals a number of strengths. You are conscientious and careful. In relationships, you are apt to be considerate and sincere.

Physical Illness or Pain

Currently, you are very preoccupied with your physical health and perhaps terrified that something is wrong with you and that others are not taking your symptoms seriously enough. You may find yourself worried about different physical sensations and concerned that they are indicating a severe disease or disorder. Your profile suggests that you may experience vague and shifting pain. In some cases, people with your profile complain of pain in a specific area of their body. In other cases, the pain seems to shift and move around their body, which can be experienced as very frightening. When you do feel pain, you may fear that it is indicating a severe and deteriorating condition.

Fatigue or Irritability

People with your profile often experience periods of fatigue, exhaustion, and depletion. Being preoccupied with your body and terrified that something is wrong with you may sap your energy and leave you feeling ill equipped for the everyday demands of life. People who experience physical illness or who have serious physical concerns tend to have little patience. People may see you as irritable and intolerant. Living with a sense of dread that something is wrong with you understandably gives you little cushion against stress.

Low Sex Drive

People with your profile tend to experience low interest in sexual activity. It's hard to enjoy sex if you're worried about your physical well-being. It may be that you experience pain during sex, or perhaps you just lack interest given how poorly you've been feeling.

Rigid or Critical

When people are afraid, they tend to get quite rigid about doing things a certain way. Anything that takes away the fear and anxiety and gives you some relief will quickly feel essential to you. You may develop some inflexible habits, compulsions, and obsessions, especially if they provide you some relief. You may also be critical of others, especially doctors or people involved in your medical treatment. You may be particularly sensitive to how people are treating you and quick to be critical of them because they do not provide you with enough comfort and relief.

Unhappy or Pessimistic

Living with a constant sense of dread about your body and illness is likely leaving you unhappy. While you may not complain of general depression, your unhappiness will be centered upon your physical problems. Even though you may want to be optimistic and positive, you tend to worry that your illness will not get better. Others may see them as pessimistic and negative. Perhaps you are afraid to be positive because you have been disappointed in the past.

Expressing Anger Indirectly

People with your profile tend not to express anger easily. When people frustrate you, the tension may cause an increase in your physical symptoms. Other people may judge your physical problems as an expression of anger or resentment toward them. This is especially true if your physical problems lead you to cancel events or prevent you from doing things that others want you to do. It's hard for you to express conflict directly, and you may worry that expressing anger toward loved ones could lead to them abandoning you when you are in pain.

Self-Centered or Demanding

Because you are so preoccupied with your body and physical symptoms, others may judge you as self-centered and selfish. They may see you as avoiding responsibility by claiming to feel poorly. It's hard not to be self-centered when you're panicked that something is wrong with you and when you're afraid that physical exertion will lead to a deterioration of your condition. Wanting to make sure that those around you are available to help is understandable when you are frightened of illness or death. Others may see you as quite demanding. It makes sense that you would want to be taken care of when you are feeling so bad.

Complaining

People may judge you as complaining because of your numerous physical symptoms. Often, people with your profile spend a great deal of time trying to find a diagnosis or cure. Over time, people around you may become impatient with you and define you as difficult. This is probably upsetting and leaves you feeling hurt and resentful.

Manipulative

Dealing with the medical system is often difficult. Because of your fear about your physical condition, you may have learned numerous ways to manipulate the system so you can be better cared for. You may find yourself having to control those around you to provide you with resources to help you feel better. Others, however, may complain, and they may refuse some of your requests and demands.

Normal-Range Feedback (T-Score 50 to 65)

Your profile shows that you are a health-conscious person who is mindful of your physical well-being. You ensure that your illnesses are well taken care of, and you are cautious about taking too many physical risks. You or someone close to you may have had a recent illness, which has made you focus on the importance of physical well-being.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Code-Type 1-2/2-1

Descriptors

Complaints

Somatic symptoms (pain, weakness, insomnia, fatigue, tremors), depression, tension, worrying, stress, general loss of interest, forgetfulness, excessive drinking—in some cases alcoholism, phobias

Thoughts

Preoccupied with physical health, lacking in insight, indecision, self-deprecating, worried, obsessive–compulsive

Emotions

Depressed, anxious, fearful, restless, irritable, insecure, denying

Traits and Behaviors

Passive or unassertive, dependent, rigid, high-strung, obsessive–compulsive behaviors, low sex drive

(Levak, Siegel, Nichols, & Stolberg, 2011)

Therapist's Notes

Individuals with mild elevations on code-type 1-2 are health-conscious people who take their responsibilities seriously. They are cautious, measured, and dutiful with a tendency to be long suffering. When stressed, they develop physical symptoms. When elevated, this profile reflects a somatizing depression, sometimes described as masked depression. Clients exhibit numerous symptoms of depression that are commingled with many vague and shifting physical complaints. Critical somatic item endorsements would indicate the current focus of their physical preoccupations. Typical complaints include abdominal pains, dizziness, headaches, food preoccupations, and a loss of sexual interest. They tend to lack insight, so stress often leads to physiological responses, which then becomes the focus of their anxiety. While they are often dutiful and responsible, they tend to shy away from conflict

and have trouble asserting themselves. Typically, they have a stable work and marital history. People with this profile tend to lack insight and to resist interpretations that their symptoms are aggravated by emotional causes or conflicts. They tend to be intro-punitive, and they may medicate their depression and tension with chemical agents; alcohol abuse can be associated with this profile.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Lifestyle and Family Background

Our hypothesis is that the 1-2 code type reflects an adaptive response to deprivation, loss, neglect, and frightening physical experiences. Limiting hope, being pessimistic, eliciting caretaking behavior from others, and worrying about physical frailty would make adaptive sense if one was subjected to prolonged periods of emotional and physical insecurity. Look for childhood histories of emotional deprivation and the encouragement of the repression of aggressive and sexual feelings. Look for early losses with the subsequent development of psychosomatic symptoms as a way to engage caretaking behavior. Somatic symptoms associated with those early losses may have successfully elicited nurturing, whereas emotional conflicts and needs were judged as unacceptable. Early experiences of poverty, parental loss, illness, and emotional deprivation could have created a somatic response to stress. Clients with this profile may have experienced a recent trauma or a work-related injury, which may have aggravated early childhood conditioning experiences of loss. In the absence of a history of somatic preoccupations, this profile may reflect a response to a recent trauma and a subsequent panic around the loss of physical integrity. (Levak, Siegel, Nichols, & Stolberg, 2011)

These individuals exhibit multiple vague and shifting physical symptoms and complaints and may experience panic about these symptoms. Sometimes there is demonstrable organic pathology, but panic around the possible dire consequences of their illness is the hallmark of the 12 codetype. The pessimism and hopelessness associated with depression is reflected in their certainty of physical decline. Their numerous somatic complaints focus on pain (e.g. headaches, stomachaches, and backaches), cardiac complaints, or gastrointestinal difficulties (e.g. anorexia, nausea, vomiting, or ulcers).

Fatigue, weakness, and dizziness are often present, along with irritability and diagnoses of dysthymia and depression. If Scales 7 and/or 9 are also elevated, then restlessness and/or intense, obsessive worrying are typical.

Persons with the 12/21 codetype usually are dependent and immature, yet can be hardworking and driven. They are often conflicted about assuming responsibilities but tend to do so, albeit in a reluctant, fearful, self-effacing way. They are often sensitive to being pushed or hurried, with easily hurt feelings. They create low expectations in others, perhaps as a way of avoiding the guilt of disappointing them. They doubt their abilities, even with evidence of

competence and, as a result, tend to be indecisive. Repression and denial of emotional problems is characteristic; they lack insight, even if emotionally sophisticated in other ways, and resist entertaining that their symptoms may be aggravated by emotional causes or conflicts. Understandably, if a person is convinced that they suffer from a fatal diagnosis, information from a therapist about emotional stress appears irrelevant. Internalization is common with depressive codetypes, so anger is rarely expressed directly and is experienced with associated guilt and self-disdain. Chemical use may be present as a way to medicate the depression. Medical patients with 12/21 codetypes are difficult to treat because they often have learned to live with symptoms shaped by numerous medical contacts and they engage family and friends' support in their quests for diagnosis and treatment. Generally, 12/21 individuals react to life's stresses with physiological symptoms, they are passive, and have a low sex drive. Dutiful and responsible, they typically have a stable work and marital history. Symptoms of depression occur, including sleep difficulties, low energy, and sad mood. Scale 9 below 50 would predict weight gain and further complaints of low energy and efficiency.

- o Concerns about health and physical functioning. Aches and pains, with accompanying emotional distress and discomfort (e.g., moodiness, unhappiness, irritability), especially somatically focused anxiety and apprehensions of serious illness, physical breakdown, and declining health. Preoccupation with somatic symptoms may obscure signs of depression (e.g., "masked depression"), such as fatigue, disturbed sleep, pessimism, and dysphoria. Tend to be overcontrolled and subassertive, passive, dependent, immature, and avoidant. May be disgruntled about their medical care. Look for cognitive problems and low intellectual efficiency, depression, substance abuse, reduced efficiency in work, and a lack of interest in leisure and recreation.

- o Somatic discomfort & pain; presents self as physically ill; concerned about health and bodily functions; Overreacts to minor physical dysfunction; symptoms likely to be in digestive system; weakness, fatigue; dizziness; resists psychological interpretations of symptoms

- o Anxious, tense, nervous; restless, irritable; dysphoric, brooding, unhappy; loss of initiative, but not clinically depressed

- o Self---conscious; introverted and shy in social situations; withdrawn and reclusive; doubts about own ability; shows vacillation and indecision about even minor matters; hypersensitive; suspicious and untrusting in relationships; passive--- dependent; harbors hostility toward those who are perceived as not offering enough attention and support

o Excessive use of alcohol is common; usually given neurotic diagnosis (hypochondriacal, anxiety, or depressive); not good risk for traditional psychotherapy; can tolerate high levels of discomfort before becoming motivated to change; utilizes repression and somatization; lacks insight and self--- understanding; resists accepting responsibility for own behavior; short---lived symptomatic changes often occur.

12/21

The most prominent features of the 12/21 code type are somatic discomfort and pain. Individuals with this code type present themselves as physically ill, although there may be no clinical evidence of an organic basis for their symptoms. They are very concerned about health and bodily functions and they are likely to overreact to minor physical dysfunction. They may present multiple somatic complaints, or the symptoms may be restricted to a particular system. Although headaches and cardiac complaints may occur, the digestive system is more likely to be involved. Ulcers, particularly of the upper gastrointestinal tract, are common, and anorexia, nausea, and vomiting may be present. Individuals with the 12/21 code type also may complain of dizziness, insomnia, weakness, fatigue, and tiredness. They tend to react to stress with physical symptoms, and they resist attempts to explain their symptoms in terms of emotional or psychological factors.

12/21 individuals are generally anxious, tense, and nervous. Also, they are high-strung and prone to worry about many things, and they tend to be restless and irritable. Although pronounced clinical depression is not common for persons with the 12/21 code type, they may report feelings of unhappiness or dysphoria, brooding, and loss of initiative. Persons with the 12/21 code type report feeling very self-conscious. They are introverted and shy in social situations, particularly with members of the opposite sex, and they tend to be somewhat withdrawn and seclusive. They harbor many doubts about their own abilities, and they are indecisive about even minor, everyday matters. They are hypersensitive concerning what other people think about them, and they may be somewhat suspicious and untrusting in interpersonal relations. They also tend to be passive-dependent in their relationships, and they may harbor hostility toward people who are perceived as not offering enough attention and support. Excessive use of alcohol may be a problem for 12/21 individuals, especially among psychiatric patients. Their histories may include blackouts, job loss, arrests, and family problems associated with alcohol abuse. Persons with the 12/21 code type most often are given diagnoses of anxiety disorders, depressive disorders, or somatoform disorders, although a small proportion of individuals with this code type may be diagnosed as schizophrenic. In this latter group (schizophrenic) , usually scale 8 also is elevated along with scales 1 and 2. Individuals with the 12/21 code type are not seen as good risks for traditional psychotherapy. They can tolerate high levels of discomfort before becoming motivated to change. They utilize repression and somatization excessively, and they lack insight and self-understanding. In

addition, their passive-dependent lifestyles make it difficult for them to accept responsibility for their own behavior. Although long-term change after psychotherapy is not likely, short-lived symptomatic changes often occur.

12s

Codes with a leading 12 pattern, although not very frequent in either normative or clinical populations, constitute one of the more important clinical configurations. As can be seen in Appendix M (see Tables 1-4) only 2-3 percent of the normals show this pattern, and men are more likely to give this combination than women. The pattern is very rare in the young group studied by Hathaway and Monachesi (1963; see Appendix M, Tables 5 and 6). Sundberg (1952; see Appendix M, Tables 11 and 12) reported a higher percentage of cases with this pattern in outpatient groups than among hospitalized psychiatric cases; the same sex difference persisted among these abnormals. In the Atlas the cases with this code fall roughly into two diagnostic groupings: somatic overconcern and schizophrenia. In the former group, constituting about two-thirds of the cases, the subordinate role of scales 3 and 7 is very important, comparing with the role of scale 8 in the latter group. The somatic group showed physical complaints, with the content centering on the alimentary system, particularly abdominal pain. These cases also were characterized by irritability and some suspiciousness. They presented a chronic and unabating hypochondriacal history. The other third of the cases were younger, with more bizarre physical complaints concerning primarily the trunk, although ranging widely over the whole trunk. They also complained of weakness and tiredness. This group was composed of schizophrenic patients who had their delusional system centered about hypochondriacal problems. Their beliefs did not seem to be any more amenable to treatment or to suggest any better prognosis than delusions reflecting other content, such as mental or interpersonal problems. L. E. Drake and Oetting (1959) indicated that the college men who came to them for counseling with 12 patterns showed tension, insomnia, and insecurity in social situations, but did not manifest gross bodily preoccupations as a typical pattern. These men were unhappy, worried a great deal, were introverted, and lacked skills in dealing with the opposite sex. The female counselees that Drake and Oetting studied presented a greater variety of problems, with physical complaints like headaches appearing, particularly when the low point in the profile was on scale 5. These girls appeared depressed, worried, and anxious. Socially they seemed insecure, shy, and self-conscious. They too lacked skills in dealing with the opposite sex. They were indecisive, lacked self-confidence, and frequently sought reassurance about the findings of any tests that they had taken. One of the prominent problems with which these women came to the counseling center was a difficulty in examinations; they tended to tighten up and block. Meehl (1951) has characterized psychiatric patients with this code pattern as persons who show irritability, depression, shyness, and even seclusiveness. The most prominent feature of the clinical picture these cases present is pain. Their complaints of pain center around the viscera in contrast with the pains singled out by the 13s who report difficulties in the peripheral organs and central nervous

system. Running through all these manifestations is a pervasive emphasis on physical symptoms and physiological processes.

Guthrie found that a large subgroup of patients seen by his urban internist had MMPI's with the 12 pattern. In his analyses, he combined the 12s and the 13's since the differences were slight. The importance of the scale 1 peak in the profile of a patient seeking medical help can here be seen; the secondary scale does not make a great deal of difference in this situation. Each patient presented numerous complaints, mainly abdominal distress and backaches, with little demonstrable physical pathology. Sullivan and Welsh (1952) reported that this pattern and the 21 pattern were associated with ulcers in their group of Veterans Administration patients. Guthrie noted only one well-demonstrated case of ulcers in his group of medical patients. Guthrie also found that 12s returned time and again with only short-lived, symptomatic relief after each visit. It seemed clear that they had learned to use their complaints to help solve their emotional problems, although it was difficult for the internist to gain any insight into the nature of their problems. This kind of scrutiny was blocked by the patient's concentration upon his physical difficulties and his lack of self-understanding. In this sample, the cases with the 12 pattern on the MM PI did not show significant changes in medical status, for either better or worse, over a period of years. As noted, the changes were slight and transitory when obtained. Guthrie found the same sex difference in his group as was described above, with men showing greater concern over physical problems and admitting fewer emotional difficulties than the women. Within his group, the 12s showed more anxiety and tension than the 13s. The twenty-two items (see the Co12 scale in Appendix I of Volume II) that differentiated this group from the other medical patients were almost entirely the frankly somatic items from the neurotic triad, with a few of the items bearing on personal inadequacy and interpersonal sensitivities from scale 7 included. Halbower's Group I. In deciding on his basic groupings, Halbower surveyed 113 Veterans Administration mental-hygiene cases undergoing treatment. He found over 16 percent of these cases had either the 12 or the closely related 21 pattern on the MMPI. On a group of 336 cases tested consecutively in the same VA installation, he found an even higher percentage showing this code pattern. He therefore decided to use this code as one of his four MMPI groups. In his derivational case selection, he imposed a rigorous set of criteria for inclusion: a 123 slope, with all three above 70; scale 7 above 70; scales 4, 6, and 9 below 70, preferably with scale 9 a low point; scale 8 less than 7 by three points, preferably below 70; F between 55 and 70 and equal to or greater than T, L, and K; the subtle score on scale 3 less than 65. Cases meeting these criteria were placed in Code Group I. He asked the therapists on these cases to make Q sorts on them, and then determined the characteristics that differentiated Code I cases from the other groups and a patient-in-general group. From these analyses he found that, according to their therapists, these particular cases had presented themselves initially as organically sick. They were manifesting either a somatization reaction or some psychophysiological reaction. Complaints of pain, weakness, and easy fatigability were prominent features of a general hypochondriacal picture.

They tended to be hypersensitive and to overevaluate minor dysfunctions. Halbower also found that these patients were described as lacking insight into their own behavior, with repression as one of the important defense mechanisms they used. They had difficulty "labeling cause and effect relationships in psychological behavior" and resisted any implication that their symptoms were related to emotional causes or conflicts. The group also showed passive dependence and dealt with anxiety and conflict in a generally "internalized fashion.

As a group these patients were relatively free of feelings of depersonalization, bizarre mentation, confusion, feelings of unreality, and suicidal thoughts. They were not characterized by reality distortions or other psychotic tendencies and were relatively free of obsessive and compulsive ruminations and self-depreciation. It should be noted that these characteristics were the ones that differentiated this group from others because of the rarity with which they were applied by the therapist-judges. The whole list of Qsort items would have to be available to provide the reader with a basis for determining the kind of items which failed to separate this group from the other code patterns being studied. In his cross-validated study, Halbower found that the Q array provided by the analyses of the criterion groups described new samples of cases with the various MMPI code patterns better, when compared to therapist descriptions of the new cases, than did rule-of-thumb interpretations by skilled judges. Thus, the pattern of descriptions given above seems to possess some appreciable validity although none of the items in the description has been individually substantiated by cross-validated analyses.

Further data on various 12 patterns are reported in the profile groupings for the 123, 1234, and 1237 types in Gilberstadt and Duker (see Chapter 3 for the defining characteristics of these MMPI patterns). Fowler and Athey (1970) have carried out a replication study of the 1234 type in Gilberstadt and Duker's schema. They reported finding in the patients seen in Alabama the same common core of general physical discomfort, depression, hostility, and heavy drinking which had emerged in the cases at the VA hospital in Minnesota where Gilberstadt and Duker obtained their samples. However, the Alabama cases were more characterized by headaches, abdominal pain, cardiac complaints, and chest pains than the Minnesota veterans and less by the direct expression of aggression in conflicts with a spouse, assaultiveness, or combativeness when drunk. Digestive difficulties, including ulcer, anorexia, nausea, and vomiting, together with tension, nervousness, and insomnia were reported for this pattern by both sets of investigators. Gilberstadt and Jancis (1967) also included further findings on the 12 code type in their analyses of the functional versus organic implications of the 13 code (see below). (Dahlstrom, Welsh, & Dahlstrom, 1979)

1-2 See also point 1a in the 1-2-3 Triad profile, p. 133.

1. People with the 1-2 combination tend to see themselves as ill and are typically depressed about this illness.
2. They tend to have medical symptoms, pain, fatigability, and overevaluation of minimal complaints (Lachar, 1974).
3. Graham (1977) has found that people with this combination complain about pain and somatic discomfort, especially in the digestive tract. They tend to react to stress with physical symptoms and resist psychological explanations for their discomfort.
4. Caldwell (1974) has hypothesized that this combination possibly indicates a phobic fear of death.
5. State hospital and mental health clinic inpatients with this pattern 1-2/2-1, were found to have multiple somatic complaints, insomnia, and physical problems. However, they seemed to be less disturbed than other state hospital patients. Older males tended to have histories of alcoholism. These findings may not apply to females (Gynther, Altman, Warbin, & Sletten, 1973).
6. In another study (Gynther, Altman, & Sletten, 1973), this pattern was found to be similar to Gilberstadt and Duker's (1965) 1-2-3-4 code type, p. 86.
7. Adolescents in treatment with this 1-2/2-1 pattern (Marks et al., 1974) were referred to treatment because of being shy and overly sensitive. They were also excessively fearful. The Marks, Seeman, and Haller book should be consulted for further information about this profile.
8. For internal medicine patients with the combination, males had two different sets of symptoms. One group of men complained of marked epigastric distress, usually of the upper gastro-intestinal tract. The other group complained of tension and depression. Both groups of men were competitive and industrious but immature and dependent. Though they dreaded increased responsibilities, they maintained their normal level of efficiency in spite of their worries (Guthrie, 1952).
9. Male college counselees with these scores tend to have tension, insomnia, insecurity in heterosexual relationships and other social situations, worry, and introversion.

10. Female college counselees with these scores (especially with a low 5 scale) tend to have headaches, depression, worry, anxiety, shyness, social insecurity, and indecisiveness (Drake & °ening, 1959).

Individuals with this high point pair tend to experience depression, worry, and pessimism, and endorse a large number of somatic complaints accompanied by a marked preoccupation with bodily functions. Symptoms are likely to include pain, weakness, and easy fatiguability, and are most pronounced during periods of stress. They may present multiple somatic complaints or the symptoms may be restricted to one particular system. There is difficulty in externalizing emotions and therefore these clients feel uncomfortable in situations demanding anger, originality, or strength. Many of their angry and hostile feelings become introjected, resulting in heightened physiological reactivity. They tend to be passive-dependent in relationships and may harbor hostility toward others who are not perceived as offering enough attention or support. A history of drug and/or alcohol abuse should be considered. A rather sour, whiny, and complaining attitude is likely accompanied by skepticism and a great deal of cynicism regarding treatment. Clients' motivation for change is quite weak, as they have learned to tolerate high levels of discomfort and because they refuse to consider physiological symptoms as signs of psychological stress. These clients consistently will seek medical attention in order to substantiate their somatic concerns. Although insight is likely to be quite limited, judgment is usually intact.

Symptoms and Behaviors

Difficulties experienced by patients with the 12/21 code type revolve around physical symptoms and complaints that can be either organic or functional (check the HEA/Health Concerns content scale). Common complaints relate to pain, irritability, anxiety, physical tension, fatigue, and overconcern with physical functions. In addition to these symptoms, a significant level of depression is present. These individuals characteristically handle psychological conflict through repression and by attending to real, exaggerated, or imagined physical difficulties. Regardless of whether these physical difficulties are organically based, these individuals will exaggerate their symptoms and use them to manipulate others. In other words, they elaborate their complaints beyond what can be physically confirmed, often doing so by misinterpreting normal bodily functions. Typically, they have learned to live with their complaints and use them to achieve their own needs. This code pattern is more frequently encountered in males and older persons.

The three categories of patients that this code is likely to suggest are the generalized hypochondriacs, the chronic pain patients, and persons having recent and severe accidents. General hypochondriacs are likely to have

significant depressive features and to be self-critical, indirect, and manipulative. If their difficulties are solely functional, they are more likely to be shy and withdrawn, whereas persons with a significant organic component are likely to be loud complainers. Furthermore, complaints are usually focused around the trunk of the body and involve the viscera. This is in contrast to the 13/31 code, in which complaints are more likely to involve the central nervous system and peripheral limbs. When the 12/21 code is produced by chronic pain patients with an organic basis, they are likely to have given in to their pain and learned to live with it. Their experience and/or expression of this pain is likely to be exaggerated, and they use it to manipulate others. They may have a history of drug or alcohol abuse, which represents attempts at “self-medication.” The most common profile associated with heavy drinkers consists of elevations in Scales 1, 2, 3, and 4. Such persons will experience considerable physical discomfort, digestive difficulties, tension, depression, and hostility, and will usually have poor work and relationship histories. The third category associated with the 12/21 code type involves persons who are responding to recent, severe accidents. Their elevations on Scales 1 and 2 reflect an acute, reactive depression that occurs in response to the limiting effects of their condition.

Personality and Interpersonal Characteristics

The 12/21 clients are typically described as introverted, shy, self-conscious, and passive dependent. They may harbor resentment against persons for not providing them with sufficient attention and emotional support. Interpersonally, they are likely to be extremely sensitive and manipulate others through references to their symptoms.

Description

Somatic disturbance, irritability, agitation, pain, anxiety, pessimism, depression, restlessness, tension, passive-dependent, concrete thinking, do not take responsibility

Possible Diagnoses

Somatoform dis., Anxiety dis., Conversion dis., Chronic alcohol intoxication, Female psychosexual dysfunction, Somatization

Modifying Scales

■ When Scale 4 is also elevated, then the individual may manipulate others through their somatic symptoms. Impulsive, demanding, self-centered, and self-defeating or self-destructive behaviors are likely.

- When Scale 9 is elevated, the profile suggests an agitated depression with mood swings. A bipolar mood disorder should be ruled out.
 - When the Repression (R) scale is elevated, there would be more inhibition and lack of insight.
 - An elevated MacAndrew Alcoholism Scale (MAC-R), Addiction Acknowledgment Scale (AAS), or Addiction Potential Scale (APS) would increase the likelihood of addiction proneness.
- (Levak, Siegel, Nichols, & Stolberg, 2011)

Female

Low 0 Tense on examinations.

Low 4 Lacks self-confidence.

Low 5 Anxieties, depressed, headaches, nervous, indecisive, tense on examinations, wants answers, socially shy, socially insecure, lacks skills with the opposite sex.

Low 6 Nonverbal, lacks self-confidence, socially insecure.

Low 9 Mother conflict.

Nothing Low Depressed, lacks skills with the opposite sex.

o **Check:** *HEA, RC1, HEA1, HEA2, HEA3, ANX, RC2, DEP, DEP1, WRK, Dr1, Dr3, Hy3, Hy4, Sc2, Sc3, Sc4, Sc6, AAS, APS.*

TREATMENT

The essence of elevated 12/21 codetypes is an underlying fear of being physically damaged, with a certainty of increasing physical illness, and even death. These clients can respond well to antidepressants. Reluctance to accept a primary diagnosis of depression is understandable, given their history of combating pain and physical infirmity, so they resist the suggestion that their medical concerns could be secondary to depression. Additional elevations on Scales 7 and 9 may require medications to treat severe agitation as well as the depression. 12/21s are vulnerable to medication dependency and side effects. Elective surgery should be avoided until the hypochondriacal aspects of the profile have been treated. Traditional insight psychotherapy tends not to work well, as they have learned to live with their complaints and tolerate high levels of discomfort. Although they may show good response to short-term treatment, symptoms are likely to return. A combination of behavioral deconditioning, Gestalt, and supportive psychotherapy seems to work best. For example, having the client's aches and pains "do the talking" may help in the expression and catharsis of blocked emotional responses. Working through early childhood losses in a supportive reparenting modality can be useful. Initially, the therapist needs to develop a therapeutic alliance by helping the

client manage medical treatment and helping them avoid doctor shopping and unnecessary medical treatments.

Encourage mindfulness therapies, yoga, and gentle exercise as stress relievers.

When giving feedback, discuss empathically how frightening and painful physical symptoms can be. Take a history focused on childhood illnesses and potential conditioning experiences around illness and death. Have the patient keep a diary of when physical symptoms occur and worsen to identify and educate how somatic sensitivity could be related to stress.

o **Treatment:** May be resistant to insight and psychological approaches. Prone to become impatient, frustrated with treatment, or both. Prefers medical explanations for emotional problems. May abuse medications for pain or sleep.

Treatment Implications

The 12/21 clients lack insight, are not psychologically sophisticated, and resent any implications that their difficulties may be even partially psychological (check the TRT/Negative Treatment Indicators scale). It is difficult for them to take responsibility for their behavior. They somatize stress, and one result is that they are able to tolerate high levels of discomfort before being motivated to change. Thus, they are not good candidates for psychotherapy, especially if the therapy is insight oriented. Typically, they seek medical explanations and solutions for their difficulties.

Therapy and Therapeutic Pitfalls

People with this profile respond well to antidepressants and very short-term anxiolytics. Somatic symptoms decrease as the depression is treated. Beware of anxiolytic drug dependency, especially if alcohol has been used for self-medication. They are likely to complain of numerous side effects of medication and become preoccupied with those side effects. Clients with this code type suffering from an actual physical injury are vulnerable to becoming dependent on compensation payments, with a reluctance to return to work. They are particularly vulnerable to panicking around physical symptoms, so an actual injury would likely cause them to regress and become more clinging and dependent. Premature pushing to return to work could lead to resistance and an increase in their physical symptoms. The clinician should determine through a history whether this profile indicates a response to a recent loss or whether it reflects a chronic pattern of somatizing depression. In the presence of a history of early emotional loss, deprivation, physical illness, and a somatizing response, any recent traumas would have aggravated an underlying personality structure associated with the 1-2 profile. Traditional insight-oriented psychotherapy tends not to work well with these clients, as shifting them away from their somatic focus too quickly is likely to create stress. They are sensitive to implied criticism or judgment, and they value being seen as responsible, dutiful, and

hardworking. They see their physical suffering as something to be borne with a sense of responsibility and duty though also resentment. Identifying and mourning past losses could alleviate the depression behind the somatic symptomatology. These clients demand reassurance and support, but they are also apprehensive about being controlled. To gain trust, help organize their medical interventions. They are particularly vulnerable in the medical system because some specialists conduct numerous diagnostic procedures, and, if negative, tend not to follow up. This causes the clients anxiety, and they may seek another medical specialty, often with similar results. Help clients reengage early childhood experiences of feeling panicked, alone, and emotionally overwhelmed—and, while experiencing these feelings, to learn to self-soothe and relax. During the therapeutic process, notice when clients experience somatic symptoms, and use relaxation and cognitive-behavioral techniques to help them establish a sense of control over pain and anxiety onset.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Treatment and Self-Help Suggestions

1. When you find yourself worrying about your health, see if you can identify any other problems or responsibilities you might be worrying about. Make a list of these worries and work with your therapist on problem solving strategies for these issues.
 2. Your therapist may suggest that you consult with a doctor about medications that could help with your anxiety and depression.
 3. Learning to assertively ask for what you want will help alleviate your depression and will give you a greater sense of control. Practice assertive requests with your therapist; role play situations where it is difficult for you to make requests. Assertive statements begin with “I” (e.g., I want; I feel; I think), “when you” (e.g., make jokes; don’t help with housework; have me work late hours), and “I would appreciate it if you would in the future” (e.g., not make jokes at my expense; do the dishes every other night; give me advance warning when you want me to work late).^{1,2}
 4. Exercise, especially aerobic exercise, can help reduce anxiety and also can help improve your mood. Try to incorporate a regular program of exercise into your daily routine.³
 5. Resilience building: Because you are preoccupied with physical illness, it may have crowded out some of the joy in your life. There is a strong correlation between happiness and a sense of purpose. Recall instances in the past where you were satisfied and had activities that kept you interested. What were the circumstances, and is there an underlying theme? See if you can identify some of the things that used to give you a sense of meaning in life.⁴ Look for small daily activities that can give you a sense of purpose and pleasure. Sometimes you will have to force yourself to begin to do something for yourself, but you will feel better later for having done it.
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¹ Clients who had more daily hassles as reported on the “Daily Hassles” form experienced more physiological and psychological health problems (Bottos & Dewey, 2004; DeLongis, Coyne, Dakof, Folkman, & Lazarus, 1982). The “Daily Hassles and Stress” form can be found at the Web site provided (Kohn & MacDonald, 1992).

² There is a distinct negative correlation between assertiveness and depression; studies have found that after learning to be more assertive subjects rate themselves as less depressed (Langone, 1979; Segal, 2005). In marital discord, depression in women is associated with low assertiveness with the spouse (Christian, O’Leary, & Vivian, 1994), and in preadolescent children, depression and low assertiveness were higher in girls than in boys; assertiveness is an especially important skill to teach adolescent and preadolescent girls (Suesser, 1998).

³ Results of cross sectional and longitudinal studies consistently find that aerobic exercise has antidepressant and anxiolytic effects. It also can protect against harmful effects of stress (Salmon, 2001).

⁴ Models of psychological well-being are linked to living a life rich in purpose and meaning. Biological correlates (immune, cardiovascular, neuroendocrine) as well as psychological well-being are included in this model (Ryff & Singer, 2008).
(Levak, Siegel, Nichols, & Stolberg, 2011)

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that currently most of the time you feel little joy or happiness. You may be feeling anxious and sad, with decreased energy, sex drive, and overall efficiency. Others may see you as pessimistic and reluctant to “let go and enjoy life.” Your worries make sense since you are experiencing physical symptoms that frighten or even panic you because you are fearful that they will get worse and you could die. These symptoms may become more intense when you become stressed. You are a dutiful, responsible person and you tend to feel guilty easily, so it is hard for you to assert yourself. You take on responsibilities and find it hard to say no to people who make demands on you. You may have experienced the death or illness of somebody close to you as a child, which led to your heightened sensitivity about any physical infirmity and your concerns about health. Explore any childhood memories when you felt frightened about illness and death. When your physical symptoms increase, see if you can link them to current stress. Rehearse with your therapist how you can be more assertive and learn how to deep breathe and self-soothe when you feel moments of panic.

Feedback Statements—Elevated Profiles (T-Score > 65)

Strengths

Your profile reveals a number of strengths. You are health conscious and take your responsibilities seriously. You are also dutiful and cautious.

Somatic Complaints

Your profile suggests that you are feeling a number of physical symptoms that may be frightening you. You may experience pains, weaknesses, insomnia, fatigue, tremors, and stomach upsets. Whenever you are stressed, these symptoms may become more severe. Physical symptoms such as nausea, headaches, and dizziness can come and go, sometimes taking you by surprise.

Depression

Your profile suggests that you are feeling quite down, unhappy, and blue. Perhaps you are feeling that you are somehow over the hill, or perhaps you're worrying that your physical problems reflect a serious medical problem that could lead to disability and even death. You may experience symptoms of depression such as anxiety, difficulties with concentration and memory, and a loss of interest in sex. Your sleep may be disturbed, and you may experience rapid changes in weight. You may have become inefficient, unable to get things accomplished the way you would like to. It may be hard for you to enjoy much right now, and even when things are going well you may find yourself feeling a dull sense of unhappiness. At other times, you may feel defeated and quite down.

Worry or Stress

Much of the time you feel tense and on edge, as if something bad is going to happen to your body and that you're going to experience some frightening physical symptoms. You may find yourself worried that some physical sensation is a sign that there is something really wrong with you. Much of the time you feel a sense of stress, so that it's hard to relax, to switch off your mind, and to be in the moment.

Excessive Drinking

People with your profile sometimes use alcohol or medications as a way to try to self-medicate their worry, depression, and physical symptoms. You might overuse prescription medications to help you sleep, relax, or turn your mind away from the constant worry about what is wrong with you physically. Heavy drinking or drug use can aggravate your physical symptoms and can complicate the treatment you receive from doctors.

Indecision

Your current level of depression and preoccupation can make it hard for you to make decisions. It's hard to make decisions about the future or to make plans about doing things with others when you're unsure about how you're going to feel by then. You may also be concerned about making the wrong choices, so you try to analyze every side of an issue to avoid making a mistake and feeling guilty.

Obsessive–Compulsive

You may spend a lot of time planning, rehearsing, and engaging in various rituals and compulsive behaviors. If a particular way of doing things made you feel better at some time, you may be reluctant to change any part of that behavior. That's how rituals and obsessive behaviors develop, because they help you feel more in control. Over time, however, they may end up controlling you.

Nonassertive, Passive, Dependent

People with your profile can be unassertive, letting other people take control. Though you may dislike being controlled by others, you do not assert yourself and do not make clear demands on others. Others may see you as quite dependent on them. When you feel physically ill and when you have frightening physical symptoms, it's understandable that you want people around you and that you want people to be available should you need them. This may make it hard for you to do things for yourself, and you may look for people to take care of you.

Rigid

People become rigid about doing things a certain way if they've been afraid of physical infirmity. You may have a tendency to get quite stubborn about doing things a certain way, especially if you feel that doing them that way helps you feel safer or less physically ill. Others may see your demands as somewhat rigid and inflexible.

Normal-Range Feedback (T-Score 50 to 65)

Your profile is within the normal range. It shows, however, that you are a health-conscious and conscientious person who takes responsibilities seriously. You tend to push yourself, have a strong work and duty ethic, and worry about things going wrong. Occasional physical symptoms of stress, such as headaches, backaches, and neck aches, can worry you about the possibility of your health declining.

(Levak, Siegel, Nichols, & Stolberg, 2011)

123/213 Codes

The elevation of Scale 3 changes the interpretation of the 12/21 codetype by adding hysterical defenses; the individual shows more “niceness,” repression, and inhibition, and a sense of long-suffering, almost cheerful, acceptance of physical ailments, with less of the complaining pessimism of the pure 12/21 codetype. The 213 person expresses multiple physical complaints that increase under stress, such as abdominal pain, weakness, cramping, dizziness, tingling and fatigue, low energy, low sex drive, and sleep disturbance. Somatization, anxiety, and depression, as well as conformity and cheerfulness, are primary characteristics associated with this codetype. Though fearful and even demanding because of their symptoms, passive dependency is likely to be present. Often there is real physiological breakdown because of years of tension and apprehensiveness, but their fears around the real physical symptoms become a debilitating focus. Men experience fear of sexual inadequacy and have low sex drive.

Women have a somewhat conflicted attitude towards sex, at once hungry for the emotional connection but also with a prudish aversion to sex, which they may find physically painful. Confused or psychotic thinking, suicidal thoughts and obsessions are uncommon, though they do complain of depression, pessimism, hopelessness, apathy, low assertiveness, low risk taking, and feelings of being “over the hill” or in declining health. They often feel that life is a strain. Self-sacrificing, reflecting Scale 3 qualities of nurture hunger, they end up feeling unappreciated by others.

Where Scale 4 is the low point, the 123/213 codetype suggests even more passivity and lack of heterosexual drive. With a low Scale 9 ($T < 50$), it suggests a low energy level, a lack of vocational aggressiveness, and a strong tendency to “take to bed” when stresses accumulate. Low Scale 5 scores in women or high Scale 5 scores in men add to the passivity and inhibition already present in the 123/213 codetype. In their unconscious drive for emotional connection and security, they become self-sacrificing and flattering of others, and assume duties, sacrifices, and burdens to the point of guilt-inducing reciprocation by others. If the *L* scale is elevated, moral rigidity and lack of psychological-mindedness can aggravate marital instability. Normally conscientious and concerned with social acceptance, an *L* elevation would predict even greater fears and concerns about social disapproval already present in the 123/213 codetype. Marks and Seeman (1963) reported that 85 percent of their sample had at least an average school performance in high school.

Very few were either above or below average, suggesting that these individuals worked hard to fit in and did not take risks or “make waves,” even during their school years. In contrast, Graham et al. (1999) reported that their participants were achievement-oriented.

o Like *1-2/2-1* but with greater chronicity, vulnerability to stress, more somatization, (paradoxically) more optimism and acceptance of physical complaints, and better social skills. Less irritability and sleep disturbance, but greater

inability to work. May be dependent, passive-submissive, passive-aggressive, conflicted about self-assertion, or a combination of these. May try to control family via symptoms/disability.

o Usually diagnosed as neurotic (hypochondriacal, anxiety, depressed) or psychophysiologic reactions; somatic complaints, particularly gastrointestinal; secondary gain from symptoms; sleep disturbance; feels despondent, hopeless, perplexed; conflicted over dependency and self-assertion; keeps others at emotional distance; low energy level; lacks sex drive; sexual problems; takes few risks; good work and marital adjustment

1-2-3 See also the 1-2-3-1 pattern. Pand point lb in the 1-2-3 Triad pattern, p. 134

1. People with this pattern are depressed, and have loss of interest, apathy, and tension (Lachar, 1974).
2. A person with this pattern (called the 1-2-3 slope) usually is male, tends to be in declining health, and feels "over the hill." He usually had poor health in childhood. Also, he does not tend to take risks or to change jobs frequently. He may feel a profound sense of loss of body functioning (Caldwell, 1972).
3. Some persons with valid physical disabilities that result in declining health also have this pattern. However, in this instance not all three scales are above 70.
4. Gilberstadt and Duker (1965) found this 1-2-3 pattern in a VA hospital male population. Men with this pattern usually reacted to stress with physiological symptoms. They tended to lack aggressiveness and sexual drive. The Gilberstadt and Duker book should be consulted for further information concerning this profile.
5. In contrast to patients with high 1, 1-3, and 1-3-4 profiles, patients with 1-2-3 combinations in one study tended to have successful lower back surgery (Long, 1981).

1-2-3

1. In this pattern, scale 1 must be higher than scale 2, and scale 2 must be higher than scale 3. This pattern is usually associated with males, and generally indicates a concern about physical problems. This concern is used frequently as a means of not facing emotional problems.

a. At lower elevations (solid line) (scales 1 and 2 above 70 and scale 3 lower than 70), mental health clients tend to be irritable, to overevaluate minor dysfunctions, and to use physical complaints seemingly to avoid thinking about psychological problems. College counselees with such a profile are usually anxious, insecure in social situations, and have insomnia or headaches. (See also the 1-2 combination, pp. 84-85).

b. An elevated 1-2-3 profile (dashed lines) (scales 1, 2, and 3 all above 70) is called a "declining health" profile. A person with this pattern is usually over age 35 and feels "over the hill" (see also the 1-2-3 combination, p. 85). This pattern is common in VA populations, male welfare and social security claimants, and long-term alcoholics. Females rarely have this elevated pattern; however, those who do and who also have a low 5 scale tend to be masochistic (see the 1-2-3-5 combination, p. 86).

123/213/231

Persons with this code type usually are diagnosed as having a somatoform disorder, anxiety disorder, or depressive disorder. Somatic complaints, particularly those associated with the gastrointestinal system, are common, and often there appears to be clear secondary gain associated with the symptoms. Sleep disturbance, perplexity, despondency, and feelings of hopelessness occur. Persons with this code type are in conflict about dependency and self-assertion, and they often keep other people at an emotional distance. They tend to have a low energy level and are lacking in sex drive. Such persons often show good work and marital adjustment, but they rarely take risks in their lives.

Description:

"Neurotic triad" - elevated in most neuroses, exaggerated need for affection

"Conversion V" - use somatic disorder as a projection channel for problems

Male

Low 0 One interview only, aggressive or belligerent, wants answers or insists on test scores. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, lack of social skills, mother conflict, being nonresponsive or nonverbal, being nonverbal or a nonrelator, being unrealistic or illogical, restlessness, unhappiness.

Nothing Low Introverted or self-conscious or socially insecure, lacks skills with the opposite sex, tense, unhappy, worries a great deal, insomnia.

Female

Low 0 Tense on examinations, marriage oriented, lacks academic drive, socially extroverted.

Low 4 Lacks self-confidence.

Low 5 Headaches, depressed, anxieties, exhaustion, insomnia, nervous, home conflict, wants answers, indecisive, distractible in study, tense on examinations, socially shy, lacks skills with the opposite sex, socially insecure.

- Note: Scale 3 coded high was infrequently associated with social insecurity.

Low 6 Lacks self-confidence, nonverbal, socially insecure.

- Note: Scale 3 coded high was infrequently associated with social insecurity.

Low 9 Mother conflict.

Nothing Low Mother conflict, father conflict, depressed, verbal, tense on examinations, lacks skills with the opposite sex.

(Drake & Oetting, 1959)

TREATMENT

Therapeutic techniques should be similar to the 12/21 codetype, using assertiveness training to express anger and unblock the repressed anger and sadness around past losses and deprivations. Look for childhood experiences with early losses of loved ones and perhaps frightening physical illnesses in the patient or someone close to them. The addition of Scale 3 suggests these individuals may have dealt with these early losses by attempting to be brave and denying or repressing understandable emotions resulting from traumatic loss, perhaps out of fear of the loss of emotional support from overburdened caretakers. Allow the patient to explore potential past losses and possible recent restimulation of the “psychological scar tissue.” A therapeutic goal would be to help them recognize and express anger directly over current frustrations as well as past losses and traumas, deconditioning them to the fear of loss associated with expressing anger.

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests you are feeling much tension and sadness and experiencing physical symptoms that may be frightening to you. At the same time, you are a responsible, dutiful person who wants to be brave in the face of pain. That is why people with your profile are sometimes described as experiencing a “smiling depression,” reflecting your need to be cheerful and positive in spite of pain or sadness. Sometimes people with this profile experienced traumatic losses as children or later, during which they had to be strong and repress understandable feelings of fear, anger, or sadness. Perhaps that is when you learned to put on a smile and be brave, sacrificing yourself in order to not upset others. Currently you may be experiencing stress that is affecting you physically and leading to feelings of depression and anxiety. Explore with your therapist any recent setbacks or losses. Take a

mindfulness class to explore some of your subtler feelings and learn to be more assertive, asking for what you want and expressing frustration without fear that you will be rejected or abandoned. Develop a realistic medical treatment plan with a medical coach to avoid repeating diagnostic tests unnecessarily. Once you have a medical treatment plan, stick to it until it has run its full course so that you can eliminate certain diagnoses without the confusion of “doctor shopping.”

1234/2134 Codes

The addition of Scale 4 modifies the interpretation of the 123/213 codetype. The expression of hostility, manipulation, self-centeredness, and alienation suggested by Scale 4 elevations are modified by the 123/213 pattern. In some cases, Scale 4 attributes are impulsively expressed after periods of repression and inhibition. In other cases, unmet dependency needs are achieved through subtle manipulation, passive dependency and addictions, even if the *MAC-R* scale is not significantly elevated. The 1234/2134 individual is dependent and highly insecure, reflecting the basic mistrust associated with an elevated Scale 4 as well as the losses associated with unavailable caretakers in early childhood. They exhibit many of the symptoms common to the 123/213 codetype, but with added cynicism, anger, and distrust in the reliability of others' caring. The 1234 individuals feel outraged when their needs are not met, and feel entitled to love and emotional security. Some 1234 individuals can be combative when intoxicated, especially when anticipating emotional rejection or abandonment. Men with this profile show hostility toward women, particularly when their dependency needs are frustrated or when they experience rejection. Poor work and marital adjustment are characteristic, accompanied by physical complaints (usually digestive difficulties, such as ulcers, nausea, vomiting, or anorexia), hostility, depression, tension, and perhaps insomnia. Yearning for emotional security and uncritical love appear to be related to histories of feeling rejected by unreliable, perhaps narcissistic, caretakers.

o Like *1-2/2-1* but with greater vulnerability to stress, intolerance of frustration, demandingness, and hostile-dependent relationships with intimates. Look for chronic alcoholism, hostility toward women (in men), ulcers, unstable employment histories.

1. Gilbexstadt and Duker (1965) found this 1-2-3-4 pattern in a VA hospital male population. Men with this pattern tended to be demanding and dependent. They developed somatic symptoms, especially ulcers and gastrointestinal disturbances. They tended toward alcoholism, which appeared to be associated with physiological hyperactivity of the gastrointestinal tract. The Gilberstadt and Duker book should be consulted for further information concerning this pattern.

2. Fowler and Athey (1971) also have found the same behavior as Gilberstadt and Duker for this code type: general psychological discomfort, depression, hostility, and heavy drinking.
3. Gynther (1974) reported Gilberstadt and Duker's (1965) description of persons with this pattern also is accurate for the populations he has studied.
4. This person may have a history of gastrointestinal difficulty. He or she may be prone to ulcers (Caldwell, 1974).

Description:

alcoholism, often hostile and acting out

TREATMENT

In addition to the therapeutic techniques indicated with the 123/213 codetype, these patients need to recognize when tension and frustration are building and to find less impulsive ways to express them. Because they are highly dependent, yet afraid to trust, they are insistently demanding of reassurance. They need reliable, consistent therapeutic support combined with caring limit-setting to help them see how their impulsive need for instant gratification can be self-defeating and frustrating to others. Their manipulative demandingness can lead to therapist counter-transference and impatience, which can restimulate their childhood experiences of a rejecting caretaker.

Insight therapy, along with behavior modification for the anger management, can help them understand how their anger is related to their unmet dependency needs in early childhood. Explore with the patient any memories of traumatic rejections and how current stressors could be restimulating past abandonment scar tissue.

Antidepressants, while useful for some, usually have to be combined with cognitive behavioral therapy (CBT) since poor selfcontrol

is characterized by this codetype.

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests you are experiencing tension, anxiety, depression, and physical symptoms such as headaches, unexplained stomach upset, weakness, and other vague symptoms that may be frightening to you. Sometimes people with your profile experienced a caretaker that was unreliable, even impatient and rejecting, so you could not trust that you were safe. You learned that you had to be a survivor, sometimes being manipulative in order for your needs to be met. Currently it is very frightening if somebody you care about is critical or rejecting of you. You may respond by feeling very angry, even explosive, and becoming controlling or demanding. When stressed, you may experience physical symptoms that shift and change; you may feel particularly alone and vulnerable to being abandoned. When

you become fearful, you may do things that are self-defeating or even destructive. Rehearse with your therapist how to control your emotions when you feel rejected or criticized. Learn to express hurt feelings as “I feel” statements rather than coming across as demanding or threatening. When your physical symptoms increase in severity, explore what other emotions you may be feeling to determine how stress affects your physical well-being. Avoid chemical agents or other addictions, as they may increase your depression and volatility.

1-2-34 (5 scale T = 45 or Below) See also point 1.b in the 1-2-3 Triad profile

Women with this combination tend to have masochistic behavior with self-depreciation, long-suffering sacrifice, and unnecessary assumption of burdens and responsibilities (Dahlstrom et al., 1972).

1-2-3-LL (L scale T = 60 or Above)

This pattern may be found in women who are characterized by one of the following (Blazer, 1965a):

- a. Having marital difficulties.
- b. Feeling sexually frigid.
- c. Complaining about infidelity or drinking by their husbands.
- d. Having menopausal difficulties.
- e. Having hysterical attacks (fear, palpitation, sweating, insomnia, and abdominal pain).
- f. Complaining of fatigue.
- g. Feeling conscientious about their work.
- h. Being easily hurt by criticism or rebuff.

1237/2137 Codes

In addition to the 123/213 codetype correlates noted earlier (see 123/213 code interpretations), the addition of Scale 7 suggests more free-floating anxiety as well as increased tension, fearfulness, guilt, and inability to be assertive. Feelings of inadequacy and highly dependent interpersonal relationships occur together with a constant preoccupation with physical symptoms and searches for explanatory diagnoses. These individuals seek constant reassurance and caretaking from others, eliciting guilt-induced sympathy because of their litany of physical ailments. If the *OBS* content scale is elevated, decision-making and sustained concentration is difficult with the individual focusing mostly on somatic symptoms and declining health, and maintaining others’ support. Helpless passivity and fears of rejection and disapproval will invite rescue, reassurance, and resentment from others. Back and chest pains,

as well as epigastric complaints, are particularly common. Complaints of weakness, moodiness, fearfulness, feelings of inadequacy, and inability to cope with everyday stress and responsibility (particularly if K and ES are below $T-50$) are typical. This pattern predicts individuals who internalize conflict and fear even minimal confrontation. People with this profile frequently marry a dominant spouse and perpetuate a role of dependency. Chronic unemployment and chemical dependency, often with prescription medications, may occur. A lack of insight, emotional inhibition, repression, and an ingratiating, conflict-avoiding disposition characterize this profile.

o Like $1-2/2-1$ but with greater vulnerability to stress and less irritability. Tense, apprehensive, fearful, and phobic. May form passive-dependent relationships with intimates and develop substance dependencies. Look for back and chest pain, cardiac complaints, and unemployability.

1. To properly evaluate disability clients who have this pattern, an important procedure is to take a thorough medical history and to look at scores on the Dependency scale (Dy) and the social responsibility scale (Re). If no long history of previous illnesses is present and the individual has a normal Dy scale (below 50) and a high Re scale (above 50), most likely the person has a disability with multiple symptoms which has developed recently with concomitant reactive depression and anxiety.
2. Gilberstadt and Duker (1965) found this $1-2-3-7$ pattern in a VA hospital male population. Men with this pattern tended to have physical complaints that may or may not have been real. They usually were weak, fearful, and unable to take ordinary stresses and responsibilities. The Gilberstadt and Duker book should be consulted for further information concerning this profile.
3. In an internal medicine population, very few of the men with this pattern had demonstrable physical problems. Women with this profile combination had a varied set of physical complaints, including epigastric distress. They complained of tension, depression, lack of energy, occasional attacks of dizziness, and fear. These women were willing to accept a chronic level of maladjustment and therefore showed poor response to treatment (Guthrie, 1952).

TREATMENT

Because of their use of repression and denial (as expected from elevations on Scales 3 and 7), memory lapses and shifts of attention away from anxiety-loaded topics can inhibit accurate history reporting. Assertiveness training and rehearsing the expression of anger, as well as supportive self-esteem building psychotherapy, are suggested. As with any codetype in which depression and anxiety are prominent, medications may be helpful; beware of suggestibility,

side effects, and habituation. These individuals are initially highly likable because of their desire to please and their ability to role-play the compliant respectful patient. They have a child-like presentation and tend to flatter the therapist, perhaps replicating how they would placate a frightening parental figure. They are quick to interpret any demands by the therapist to explore undesirable emotions or rehearse more assertive behavior as displeasure with them. This can result in premature termination. Behavioral therapies to teach self-soothing can be useful, given that many experienced chaotic childhoods with unpredictable emotional support. In childhood, they may have experienced unpredictable rages directed toward them by caretakers or siblings and peers, where they feared for their lives or the lives of their loved ones. Behavioral deconditioning of fear of anger can also be useful.

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you live with an almost constant sense of tension, dread, guilt, and worry. Much of the time your body is a source of worry because you likely experience numerous physical symptoms that are frightening to you. Confronting others or expressing anger is difficult because conflict frightens you. Perhaps you have experienced somebody close to you who was unpredictably angry and rejecting and you have learned to play the right role to please others and avoid their displeasure. Asserting yourself is difficult, so you may let people control you and take advantage of you. You feel so guilty when you make a mistake that you may invite others to tell you what to do and take care of you. When stressed, your physical symptoms may increase to the point where you feel intense anxiety or panic. Explore any memories of an unpredictably angry caretaker and allow yourself to feel normal self-protective anger. Work at being more assertive and learn to switch off guilty feelings when you express irritation towards others. Using CBT, learn to soothe yourself when you experience periods of panic. Take yoga classes and use gentle exercise as a way of relieving stress.

124 Code

o Like *1-2/2-1* but more irritable, depressed, and alienated. Prone to complaining, bitterness, and noncompliance with treatment if not active in efforts to defeat or sabotage treatment. See *1-4/4-1*; *2-4/4-2*.

Male

Low 0 Father conflict, aggressive or belligerent.

Nothing Low Introverted or self-conscious or socially insecure, lacks skills with the opposite sex, tense, unhappy, worries a great deal, insomnia.

- Note: Scale 4 coded high was infrequently associated with lack of skills with the opposite sex.

Female

Low 0 Anxieties, depressed, father conflict, indecisive, lacks skills with the opposite sex, socially extroverted, tense on examinations, lacks academic drive.

- Note: Scale coded low was infrequently associated with depression and lack of skills with the opposite sex.

Low 3 Anxieties, depressed, father conflict, indecisive, lacks skills with the opposite sex.

Low 5 Anxieties, depressed, headaches, nervous, father conflict, mother conflict, rebellious toward home, indecisive, lacks skills with the opposite sex, socially shy, socially insecure, tense on examinations, wants answers.

- Note: Scale 4 coded high was infrequently associated with social insecurity.

Low 6 Anxieties, depressed, father conflict, indecisive, lacks self-confidence, nonverbal, vague goals, lacks skills with the opposite sex, socially insecure.

- Note: Scale 4 coded high was infrequently associated with social insecurity.

Low 7/8 Anxieties, depressed, father conflict, indecisive, lacks skills with the opposite sex.

Low 9 Anxieties, depressed, father conflict, mother conflict, indecisive, lacks skills with the opposite sex.

Nothing Low Anxieties, depressed, father conflict, indecisive, lacks skills with the opposite sex.

(Drake & Oetting, 1959)

125 Code

Male

Low 0 Home dependency, worries a great deal, wants reassurance only.

- Note: Scale coded low was infrequently associated with worrying a great deal. This pattern was infrequently associated with introversion or selfconsciousness or social insecurity, being nonresponsive or nonverbal, tension.

Low 3 Home dependency, wants reassurance only, worries a great deal.

Low 4 Home dependency, home conflict, wants reassurance only, worries a great deal.

Low 6/7/8/9 Home dependency, wants reassurance only, worries a great deal.

Nothing Low Introverted or self-conscious or socially insecure, lacks skills with the opposite sex, home conflict, home dependency, wants reassurance only, tense, unhappy, worries a great deal, insomnia.

- Note: Scale 5 coded high was infrequently associated with tension.

Female

Low 0 Tense on examinations, socially extroverted.

Low 4 Lacks self-confidence.

Low 6 Lacks self-confidence, nonverbal, socially insecure.

Low 9 Mother conflict.

Nothing Low Depressed, distractible in study, lacks skills with the opposite sex.

- Note: Scale 5 coded high was infrequently associated with depression.

126 Code

Male

Nothing Low Introverted or self-conscious or socially insecure, lacks skills with the opposite sex, tense, unhappy, worries a great deal, insomnia.

Female

Low 0 Anxieties, resistant in the interview, 8+ conferences, tense on examinations, socially extroverted.

Low 3 Anxieties, 8+ conferences.

Low 4 Anxieties, 8+ conferences, shy in the interview, lacks self-confidence.

Low 5 Anxieties, depressed, nervous, headaches, nonresponsive, wants answers, 8+ conferences, physical inferiority, indecisive, tense on examinations, socially shy, socially insecure, lacks skills with the opposite sex.

Low 7/8 Anxieties, 8+ conferences.

Low 9 Anxieties, 8+ conferences, mother conflict.

Nothing Low Anxieties, depressed, restless, 8+ conferences, lacks skills with the opposite sex.

(Drake & Oetting, 1959)

127 Code

o Like 1-2/2-1 but more overtly anxious, obsessive, and self-conscious, and with more disturbance in routine cognitive functions. Disturbed sleep. More dependent but fewer conflicts over dependency; higher threshold for acting out. See 1-7/7-1; 2-7/7-2.

Male

Low 0 One interview only, tense, tense on examinations, indecisive, unhappy, worries a great deal, lacks knowledge or information.

- Note: Scale coded low was infrequently associated with indecisiveness, unhappiness, worrying a great deal.

Low 3/4/5/6/8 Tense, tense on examinations, indecisive, unhappy, worries a great deal.

Low 9 Tense, tense on examinations, indecisive, unhappy, worries a great deal, generally dependent.

Nothing Low Introverted or self-conscious or socially insecure, lacks social skills, lacks skills with the opposite sex, home conflict, mother conflict, sibling conflict, nonresponsive or nonverbal, tense, tense on examinations, indecisive, unhappy, worries a great deal, insomnia, confused.

Female

Low 0 Anxieties, depressed, socially insecure, socially shy, distractible in study, tense on examinations, lacks self-confidence, 4 to 7 conferences.

- Note: Scale coded low was infrequently associated with depression, social insecurity, social shyness.

Low 3 Anxieties, depressed, socially insecure, socially shy, distractible in study, lacks self-confidence, 4 to 7 conferences, cried in the interview.

Low 4 Anxieties, depressed, socially insecure, socially shy, distractible in study, lacks self-confidence, 4 to 7 conferences.

Low 5 Anxieties, depressed, nervous, exhaustion, headaches, insomnia, distractible in study, tense on examinations, lacks self-confidence, indecisive, 4 to 7 conferences, wants answers, socially insecure, socially shy, lacks skills with the opposite sex.

Low 6 Anxieties, depressed, distractible in study, lacks self-confidence, 4 to 7 conferences, nonverbal, socially insecure, socially shy.

Low 8 Anxieties, depressed, distractible in study, lacks self-confidence, 4 to 7 conferences, socially insecure, socially shy.

Low 9 Anxieties, depressed, distractible in study, lacks self-confidence, 4 to 7 conferences, socially insecure, socially shy, mother conflict.

Nothing Low Anxieties, depressed, headaches, distractible in study, lacks self-confidence, 4 to 7 conferences, socially insecure, socially shy, lacks skills with the opposite sex, sibling conflict.

(Drake & Oetting, 1959)

128/218 Codes

This is primarily a depression profile, with schizoid and somatizing features. Sometimes physical complaints are odd or bizarre, reflecting the depth of the individual's depression and damaged self-esteem. Complaints of fatigue, weakness, tension, insomnia, sadness, low energy, and motivation are typical of the 12/21 codetype. The Scale 8 elevation adds an increased likelihood of motor and/or sensory complaints, and severity to the disturbance in cognitive processing associated with depression. Consequently, these individuals complain of difficulties with thinking, memory and concentration, decision making and daily organization. Some will complain that they literally feel they are "losing their mind," reflecting the primacy of cognitive problems. Feelings of alienation from others and

a sense of being hopelessly broken or damaged, combined with feelings of severe physical deterioration, characterize the 28/82 codetypes. Individuals with the 128/218 codetype may become passively dependent on others because of their cognitive decline. Sexual drive tends to be low or non-existent, and emotional closeness is experienced as frightening. Some may be pre-psychotic or psychotic with somatic delusions, but most are not psychotic. Rather, the codetype suggests a severe depression with feelings of inevitable physical and cognitive decline.

o Like *1-2/2-1* but more overtly depressed, with greater overall levels of distress, apprehension, weakness/fatigue, apathy, and disability, and more cognitive disruption, more impaired self-esteem, and less adequate behavioral controls. A greater proportion of neurologiclike symptoms, motor, sensory, and cognitive (e.g., concentration, memory), and a relatively high likelihood of symptoms that are peculiar if not delusional, along with disturbed sleep. There is greater alienation from others, less adequate social skills, significantly reduced efficiency, and greater anger and cynicism. See *1-8/8-1*; *2-8/8-2*.

Male

Low 0 Introverted or self-conscious or socially insecure (28), lacks skills with the opposite sex, lacks knowledge or information, aggressive or belligerent.

- Note: Scale coded low was infrequently associated with lack of skills with the opposite sex, introversion or self-consciousness or social insecurity.

Low 3/4/5/6/7 Introverted or self-conscious or socially insecure, lacks skills with the opposite sex.

Low 9 Introverted or self-conscious or socially insecure, lacks skills with the opposite sex.

Nothing Low Introverted or self-conscious or socially insecure, lacks skills with the opposite sex, tense, indecisive, unhappy, worries a great deal, insomnia, confused.

Female

Low 0 Anxieties, depressed, distractible in study, tense on examinations, verbal, lacks skills with the opposite sex.

- Note: Scale coded low was infrequently associated with depression and lack of skills with the opposite sex.

Low 3 Anxieties, depressed, distractible in study, lacks skills with the opposite sex.

Low 4 Anxieties, depressed, distractible in study, lacks skills with the opposite sex, lacks self-confidence.

Low 5 Anxieties, depressed, headaches, nervous, distractible in study, tense on examinations, lacks skills with the opposite sex, socially shy, socially insecure, wants answers, indecisive.

Low 6 Anxieties, depressed, distractible in study, lacks skills with the opposite sex, socially insecure, lacks self-confidence, nonverbal.

Low 7 Anxieties, depressed, distractible in study, lacks skills with the opposite sex.

Low 9 Anxieties, depressed, distractible in study, lacks skills with the opposite sex, mother conflict.

Nothing Low Anxieties, depressed, distractible in study, lacks skills with the opposite sex, father conflict, mother conflict, sibling conflict, 8+ conferences.

(Drake & Oetting, 1959)

TREATMENT

Antidepressant medications are often appropriate. Insight psychotherapy should be avoided, as this type of therapy tends to be disorganizing and confirming of their negative self-esteem. Childhood histories often show cold, withdrawn caretakers and emotional deprivation. Supportive, motherly therapists that reparent the individual can be effective, although short-term treatment strategies such as cognitive restructuring, self-esteem building, and assertiveness training are also often useful. These individuals suffer from a profound negative self-image and feelings that they are hopeless, emotionally and physically damaged and unlovable, so therapies that enhance self-esteem quickly are most likely to be helpful. Do not expect, however, a quick positive transference, as these individuals fear that closeness will lead to abandonment and rejection.

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you are feeling down, blue, unhappy, and unable to think as clearly as you would like. Currently it may be hard for you to focus, make decisions or be very efficient. Your sleep may be disturbed and you may have low energy. You may be experiencing physical symptoms which frighten you, and leave you preoccupied and worried. Sometimes you may feel that there is something really wrong with you because it is so hard for you to think clearly, remember things, and be efficient in your daily life. Much of the time you may feel as if you are in a mental fog, which frightens you and leads to you feel hopelessly defective. You may keep people at an emotional distance because you are afraid that you will be humiliated and rejected if you depend on others. In some cases, people with your profile grew up with caretakers who could be cold and withdrawn, even cruel. You may have learned to protect yourself by not allowing people to be close to you. Recently you may have experienced some medical problems or some other loss, leading you to feel sad, hopeless, and bad about yourself. Explore with your therapist any recent losses or setbacks which could have led to your current depression. Medication may help you to feel less sad and enable you to think more clearly. Make a list of some of your positive attributes so you can remind yourself of them when you feel hopelessly defective. Work on mindfulness so you can express how you feel to others. Develop exercises with your therapist that can help you remember better and be more efficient until medication can improve your overall efficiency.

129/219 Codes

When Scales 1, 2, and 9 are all elevated at about the same level, it is difficult to discern whether this is a primary affective disorder with mood instability creating secondary psychosomatic complaints or whether this is a somatizing depression with agitation (reflected in the Scale 9 elevation) as a secondary component. As one would expect, given the 29 component of the elevation, there is substantial mood instability and agitation.

Sometimes the 29 aspect of the profile is reflected in transient mood swings. Sometimes the euphoria of the Scale 9 profile is cancelled out by the depression, and the low energy and sadness of the Scale 2 is modified by the Scale 9 attributes, leading to tension, irritability, and mood swings within a few minutes of each other, and usually precipitated by real or imagined setbacks or obstacles to goal-driven activity. Somatic concerns are greatly distressing to the 29 individual, who responds to them as virtual emergencies. Acute distress, tension, agitation, and restlessness are prominent. Headaches, insomnia, and complaints such as spastic bowel are frequent. A neurological etiology should be considered because in a minority of cases this pattern has been associated with organic brain syndrome. It is also possible that the elevation on Scale 9 reflects a hypomanic defense against depression and the somatic symptoms reflect the tension inherent in experiencing contradictory defensive responses.

o Somatization and emotional turmoil or agitation. Possible panic over physical symptoms. Consider neuropsychological evaluation. See *1-9/9-1*; *2-9/9-2*.

Description:

acute clinical distress, neurological problems, masked depression

Male

Low 0 Tense on examinations, aggressive or belligerent, rationalizes a great deal. This pattern was infrequently associated with introversion or selfconsciousness or social insecurity, shyness in the interview, being nonresponsive or nonverbal, being nonverbal or a nonrelator, indecisiveness.

Low 3/4/5/6/7/8 Tense on examinations, aggressive or belligerent, rationalizes a great deal.

Nothing Low Introverted or self-conscious or socially insecure, lacks skills with the opposite sex, tense, tense on examinations, unhappy, worries a great deal, insomnia, aggressive or belligerent, rationalizes a great deal.

- Note: Scale 9 coded high was infrequently associated with lack of skills with the opposite sex and worrying a great deal.

Female

Low 0 Lacks self-confidence, socially insecure (29) , socially extroverted (9-0) tense on examinations, marriage oriented, verbal.

- Note: Scale coded low was infrequently associated with social insecurity.

Low 3 Lacks self-confidence, socially insecure, vague goals.

Low 4 Lacks self-confidence, socially insecure, shy in the interview, nonresponsive.

- Note: Scale 9 coded high was infrequently associated with shyness in the interview.

Low 5 Lacks self-confidence, indecisive, socially insecure, socially shy, lacks skills with the opposite sex, anxieties, nervous, depressed, exhaustion, headaches, tense on examinations, verbal, wants answers.

Low 6 Lacks self-confidence, socially insecure, nonverbal.

Low 7/8 Lacks self-confidence, socially insecure.

Nothing Low Lacks self-confidence, socially insecure, lacks skills with the opposite sex, depressed.

(Drake & Oetting, 1959)

TREATMENT

Psychotherapy is complicated because somatizing defenses and responses are co-morbid with a mood disorder.

Where emotional lability and depressive symptoms are primary, antidepressant and mood stabilizing medications may be useful, although some clients may develop mania in response to antidepressants. A history of mood instability would suggest using a mood stabilizer, with an antidepressant added at a later date, if needed. Treatment strategies are dependent on a diagnosis that is complicated for the 129 individual. Medication may be primary if history suggests lifelong mood instability. If the precipitating event is a perceived loss, therapy to identify why the loss is experienced as catastrophic would be relevant. Help the patient to (a) identify the current loss or failure, (b) distinguish between their own wants and internalized parental expectancies for high achievement and, (c) identify the triggers for mood changes and use CBT to manage them. Usually people with this profile experience intense fears of failure and the expected resulting emotional abandonment and disapproval. Alcoholism or other addictions are associated with this codetype.

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you are experiencing a great deal of internal tension, irritability, and anger, usually set off by what you see as a frustration or somebody interfering with what you want. You may find yourself experiencing mood swings, sometimes feeling highly energized and even euphoric, and then something sets you off and you become down, angry, and irritable. These mood swings can come and go within a few minutes of each other, or with longer intervals in between. You may use chemical agents or some other addictive behaviors as a way to deal with

these mood swings, but they likely cause you more problems. Your tension may become so intense that you develop real physical responses to stress that frighten and preoccupy you. You may have experienced a recent setback or loss that precipitated this agitated and moody response or you may have had a tendency toward mood swings for a period

of time. Your therapist may prescribe a mood stabilizing medication and explore what triggers your mood swings so you can learn to control them. In some cases, an accident or injury can precipitate some of these symptoms. In some cases people with your profile feel the need to achieve a great deal in order to feel lovable. Explore with your therapist what kind of pressure you feel to achieve great things in order to feel acceptable. Keep a diary of events that trigger your mood swings and learn to self-soothe so that you avoid catastrophizing when things go wrong. Exercise, yoga, and deep breathing can all be helpful.

120/210 Codes

Typically, the 20/02 codetype, without Scale 1 elevation, is a stable code, as is the 12/21 codetype. Taken together, these elevations predict depression, withdrawal, indecisiveness, interpersonal avoidance, and feelings of inadequacy and guilt. Somatic complaints and a quiet, defeatist, negative attitude are typical. Such persons are distinctly lacking in joy and are defensively aloof. They accept physical suffering as their lot in life, even as they can be demanding of their caretakers. Passive and attention-avoiding, unless focused on physical ailments, some can withdraw in a misanthropic or schizoid fashion, particularly if Scale 6 or 8 is also elevated. Life for the 120/210 is emotionally constricted and they have low expectations for happiness. They are irritated and even offended by demands for intimacy and the invasion of their personal space by others trying to be overly friendly.

o Somatization and withdrawal. Schizoid features with dysphoria/ depression and defeatism. Check fourth highest scale.

TREATMENT

History would determine whether this is a stable, introverted, typically non-depressed personality type who has recently become depressed and somatic due to a specific perceived loss, or a profile reflecting a long history of dysphoria, somatic preoccupation and introversion. Assertiveness training and CBT with social skill building could help deal with the depression and social awkwardness which often contributes to their depression and lack of social support. Antidepressants, as with all depression profiles, could help alleviate dysphoria, although medication should be given in small doses, as these disorders tend to be longstanding and any rapid change tends to be experienced as uncomfortable. Childhood histories often reveal parental emotional and physical aloofness, and a lack of warmth,

although without overt hostility. Many of these clients experienced a loss of childhood carefreeness because of demands on them to be prematurely adult and responsible, perhaps due to illness in themselves or others. Problem-focused therapies that are not demanding of intimacy tend to work best. For example, 60-year-old Steven was brought to therapy compliantly by his wife because she felt there was something wrong with him. She complained he appeared even more distant than usual. When she told him she had been diagnosed with breast cancer he had said nothing and never discussed it with her. He was a scientist at a famous California academic institution and had done very well working alone in the lab as part of a loosely structured team. Their marriage had come late in life, they had no children, and he and his wife followed the philosophy of Ayn Rand. His 210 codetype was congruent with a life of comfortable isolation and parents who rarely spoke or physically touched one another. There was no family conflict in his family of origin. They cared for his physical needs adequately and made few demands on him. He and his wife lived as comfortable roommates, with rare but mutual sexual relations and little conflict. They both worked and kept separate bank accounts, splitting their expenses down the middle. When she developed cancer and quit her work, she needed more intimacy and warmth and became more demanding. She was also introversive, but not to his extent, so the loss of her work relationships after her cancer diagnosis resulted in more demands on him. As he felt overwhelmed by her increasing criticisms of him for failing to be emotionally supportive, he became increasingly depressed and complained of constant physical ailments, which had an indeterminate diagnosis. Therapy involved teaching him how to be supportive and an available listener. He took notes, asked questions, and followed concrete advice without the destabilizing intimacy of insight therapy.

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests you are a somewhat shy person, comfortable being alone and not needing a lot of social interaction. You might enjoy socializing with small groups of people you know well, but find social events with groups of strangers taxing and unpleasant. You are probably a dutiful, responsible, quiet person who avoids drawing attention to yourself. You may avoid conflict, at times to your detriment, and you probably are not very assertive. Currently you may feel a little down, sad, even depressed, perhaps feeling negative about your current situation. You may feel reduced energy, general inefficiency, and your sleep and appetite and sex drive may be affected. You may be experiencing a number of physical symptoms that are linked to your current depression, and you may feel concerned, even defeated, by these symptoms. You have likely been a self-contained person most of your life, but you may have recently experienced some setbacks or losses which have gotten you down. Your therapist may suggest medications to help you feel better and also help you learn to deal with social situations so that they are less stressful.

13/31 Codes

(see also Conversion V)

Code-Type 1-3/3-1

Descriptors

Complaints

Somatic complaints (aches and pains in the head, neck, chest, back, extremities), insomnia, weakness, fatigue, dizziness, numbness, blurred vision, eating problems or nausea, forgetfulness, symptoms increase under stress, fear of physical pain and infirmity, anxiety and sometimes phobias, low sex drive

Thoughts

Positive and cheerful in the face of pain, focused on physical problems, repressed, denying

Emotions

Insecure, repressing anger, overcontrolled, strong need for approval and affection

Traits and Behaviors

Dependent, passive, somatizing, repressed, inhibited, conflict avoidant

(Levak, Siegel, Nichols, & Stolberg, 2011)

Therapist's Notes

People with mild 1-3 elevations dislike confrontation and work hard to keep the peace. They are people pleasers and conflict avoiders, and in seeing the positives and finding the best in people they employ some repression and denial. Higher elevations reflect numerous physical complaints and preoccupations with fears of bodily damage, illness, and general health decline. It is important for these clients to be liked by their doctors and therapists, and they tend to be generally socially adaptable and appropriate. They are inclined to get along well with others and to avoid direct conflict. In spite of their fear of bodily damage, they want to be seen as reasonable, appropriate, and likeable. They do not exhibit psychotic, paranoid, or thought disturbance symptoms, as this is a neurotic disorder. They do, however, complain of forgetfulness, concentration difficulties, eating problems, and pseudo-neurological symptoms perhaps associated with the repression of the underlying depression. Elevations on Scale 3 suggest repression, an avoidance of conflict, and needs for approval, attention, and emotional connectedness. When Scale 1 and Scale

3 are elevated and Scale 2 is significantly lower (by a T-score of approximately 8 or more), the depression is masked by a cheerful and positive attitude and braveness in the face of complaints of physical pain and infirmity. The clients' main focus is physical symptoms, and though they express panic, despair, and rumination about their physical well-being they stay brave and positive in the face of their concerns. This profile has been called the psychosomatic or conversion "V," reflecting the elevations on 1 and 3 and the low score on 2, producing a V-shaped MMPI-2 profile pattern. For these clients, repression is a major defense, so they are likely to complain of weakness, fatigue, headaches, dizziness, numbness, blurred vision, tremors, genital pain, and, in some cases, anorexia. In other cases, complaints of gastrointestinal disturbance with nausea, vomiting, and ulcers are reported. Perhaps because of their profound fear of physical illness and precipitous decline, they are apt to be demanding of others' attention, affection, and support.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Lifestyle and Family Background

It is hypothesized that early illness in clients or death of their close relatives conditioned in them fear of bodily damage, death, and loss. In one sample (Marks & Seeman, 1963), 30% were ill as children, and 30% had mothers who were also ill. Death of a parent was noted in 60% of the sample. Parental relations toward the child were described as "affectionate." Our hypothesis is that individuals with a 1-3 code type responded adaptively to such losses with attempts to be brave, to smile in the face of pain, and to maintain contact with others to gain emotional support. Repressing anger, being overly nice, and inhibiting socially unacceptable impulses would serve to keep them in contact with others in case they need support in the event of physical infirmity. These individuals tend to be highly suggestible and can quickly develop obsessive thoughts about a particular illness or infirmity. We see suggestibility as an adaptive response in an individual who has experienced the death or illness of a loved one. Being hyper alert to all possible symptoms and unusual physical experiences, even those suggested by others, maximizes alertness to physical danger and therefore the possibility of a quick response. It is understandable that someone who is terrified of infirmity would be personable, would work hard to avoid disapproval, and would want to be seen as cheerful and likeable.

(Levak, Siegel, Nichols, & Stolberg, 2011)

These individuals are typically preoccupied with numerous physical problems, but the most common complaint is one of pain, which usually centers on the extremities: head, back, neck, arms, eyes, and legs. A variety of specific and vague somatic worries control their lives, as they are vulnerable to developing physical symptoms in response

to stress. Nausea or discomfort after eating, anorexia or bulimia, elimination difficulties and related concerns preoccupy them. Complaints of fatigue, dizziness, numbness, and tremors are common. Severe anxiety (other than that associated with physical symptoms) or complaints of depression usually are absent, although some patients report depression due to physical concerns. Sleep disturbances and low sex drive are common. The elevation on Scale 3 generally tempers the pessimistic, complaining cynicism shown by high Scale 1 individuals. If Scale 2 is coded third, then depression and pessimism are evidenced, although expressed through the defense of repression and denial, as resignation borne with long suffering niceness. If Scale 7 is elevated along with the 13/31 codetype, then anxiety, tension, and guilt also are present, with even more fears of conflict and the expression of anger. If Scale 8 is the third most elevated scale, the patient also may complain of dizziness, losses of consciousness, sexual preoccupations, and bizarre physical symptoms. If Scale 9 is elevated along with the 13/31, then there is more emotionality, approval seeking, denial, and explosiveness. Note that some 139 codetypes have been associated with chronic brain syndromes. Few clients with 13/31 codetypes are incapacitated by their symptoms and they continue functioning, albeit at a reduced level of efficiency. Unless the *K* scale is below a *T*-score of 45, reflecting lowered emotional control, they present themselves as reasonable and responsible “good patients” who are suffering from pain and associated worries, but, in all other ways, well-adjusted. How they are seen by others is very important to them, so they often question psychological inquiry and resent the implication that their somatic concerns are “in their heads.” They have a high need for social approval, and have strong values about being seen as cheerful, contented, and “brave in the face of pain.” If the *L* and *K* scales are elevated, there is even more repression, denial, and fear of being judged. As a result, these individuals are difficult to engage in psychotherapy. They seek medical explanations for their problems and lack insight into psychological factors that may underlie or influence their problems. Some will exhibit demonstrable physical breakdown, perhaps a result of prolonged stress.

These individuals show a strong need for attention, affection, and sympathy, and feel insecure without them. Often their physical complaints produce secondary gains, such as caretaking behavior from others, particularly if the pattern is a Conversion V. Because these individuals are so concerned and frightened about their ailments, they need constant support and reassurance. As a result, they are described by others as immature, egocentric, dependent, and selfish. Although generally outgoing and sociable (particularly if Scale 0 is below *T*-50), their social relations tend to be focused on meeting their needs for reassurance. Given their extreme fears regarding body damage, it is surprising that many are described as optimistic (especially if Scales 2 and 7 are within the normal range), but the description reflects their genuine desire to be acceptable and liked and not a problem for others. They do not express anger or resentment directly, so negative emotions and stress are expressed somatically. Others may judge them as passive-aggressive, perhaps experiencing their agreeableness and self-effacing demandingness as frustrating. Marital relationships, unless the spouse is a co-dependent, can become strained because of the 13 individual’s incapacitation

and inability to provide the reciprocal rewards necessary in a marriage. If Scale 1 is higher than Scale 3 by at least 10 *T*-scores, the codetype predicts hypochondriacal features with associated complaining and pessimism. The Scale 1 attributes are predominant and less modified by the hysterical needs for reassurance and approval. A 31 codetype with Scale 3 higher than Scale 1 by 10 *T*-scores or more will predict more ingratiating niceness and need for social approval, with physical complaints stoically suffered and activated by stress. The repression and denial driven by the need for emotional connection associated with Scale 3 predominates and Scale 1 attributes are expressed through Scale 3 defenses. It is interesting to note that 60 percent of the individuals with 13/31 codetypes experienced the early death of a parent (Marks & Seeman, 1963). They described these parents as affectionate. Levak (Levak et al., 2011) posited that the MMPI-2 codetypes can reflect an adaptive response to a perceived stressful event, in this case the loss of a loved and possibly loving parent. This codetype suggests that in response to loss, the 31 individual adapted by being “brave” in the face of pain, and blocking the expression of anger surrounding it.

The 13/31 codetype is the second most common among parents of child psychotherapy clients. It is associated with mothers who are overprotective, extraverted and suggestible, and both mother and child tend to show improvement. The prognosis is less favorable for fathers, who exhibit immature dependency, strong needs for acceptance, and the use of subtle and indirect strategies to gain affection and attention from the child. College women with this profile describe themselves as affectionate and thoughtful. Their peers, however, see them as somewhat selfish, self-centered, dependent, attention-seeking, irritable, emotional, high-strung, and with frequent physical complaints. Often there is a strong relationship orientation, with less academic focus, which can become a source of further stress. College men with this profile likewise are seen as selfish, dependent, self-centered, and demanding. One of their primary complaints is that they do not get enough consideration from their families. Most appear socially at ease, fluent, expressive, and confident (particularly if *K* is high and 0 is low). In psychological settings, they often assertively insist on knowing their test results and on being given concrete answers to their problems. They tend not to persist in insight therapy although they may find supportive problem-solving therapies useful.

Definition: Scale 3 must exceed Scale 2 by at least 8 *T*-scores. Ideally, Scales 1 and 3 should exceed Scale 2 by at least 10 *T*-scores, and Scale 2 should exceed all other scales by at least 5 *T*-scores.

o Individuals are preoccupied with somatic symptoms and health problems about which they show mild anxiety, and they are prone to develop physical symptoms under stress. Far fewer somatic symptoms than 1-2/2-1, and these tend to be localized to the extremities or to involve problems around eating. Numbness, tremor, dizziness, and fatigue are common. Not incapacitated, but inefficient and easily tired. Socially skilled, forward, and outgoing.

Expressive but also inhibited. Conventional, if not moralistic, and over-controlled. Wants to be seen as self-confident, upbeat, friendly, cheerful, trusting, responsible, and normal; prefers to have things nice, pleasant, and happy, and seeks to achieve this by carrying on despite symptom(s), looking at things on the bright side and avoiding things that might be unpleasant or upsetting. Subtle avoidances of responsibility. Seen as more dependent and demanding by others than by self. Doesn't like to complain; may feel worse than appearance would suggest.

- o Usually diagnosed as psychophysiologic or neurotic (hysterical, hypochondriacal); classic conversion symptoms may be present; severe anxiety and depression absent; functions at reduced level of efficiency; physical symptoms increase under stress and often disappear when stress subsides

- o Prefers medical explanations of symptoms; resists psychological interpretations; denying, rationalizing, unsightful; sees self as normal, responsible, and without fault; lacks appropriate concern about symptoms and problems; overly optimistic and Pollyannaish

- o Immature, egocentric, selfish; insecure with strong needs for attention, affection, sympathy; dependent but unaccepting of dependency; outgoing and socially extraverted but relationships are superficial; lacks genuine involvement with people; exploits social relationships; lacks skills in dealing with opposite sex; may lack heterosexual drive

- o Harbors resentment and hostility toward those who are perceived as not offering enough attention and support; over-controlled; passive---aggressive with occasional angry outbursts; conventional and conforming in attitudes and beliefs

- o Not motivated for psychotherapy; expects definite answers and solutions to problems; may terminate therapy prematurely when therapist fails to respond to demands

Individuals with this high point pair are generally immature, egocentric, and demanding, with hysteroid characteristics and repressive defenses. If there are elevations on Scale 2, then this implies that these repressive defenses are not working effectively. Such clients are prone to develop any of a variety of circumscribed conversion symptoms. Although these symptoms may be based in some actual organic pathology, they generally arise after protracted periods of tension in clients with a history of insecurity, immaturity, and well-established proclivity to physical complaints. They are likely to be quite demanding of attention and affection and will attempt to receive this through unobtrusively manipulative means. Rarely are such clients seen as psychotic. Denial is a major defense, as they manifest an overly optimistic and Pollyannaish view of their situation and of the world in general, and they may

not show appropriate concern about their symptoms. Overcontrol is likely, as they will go to great lengths to inhibit the expression of hostile and aggressive feelings. This internalization of impulses occurs in almost every area except with the possibility of sexual acting-out behaviors. Many of these clients are especially vulnerable to narcissistic injury in heterosexual relationships. In psychotherapy, clients with this high point pair will want immediate concrete solutions to their difficulties and will terminate prematurely when the therapist fails to respond to their excessive demands for attention. Individuals with this high point pair lack insight into the nature of their behaviors and are very resistant to interpretations that could imply psychological explanations of their physical difficulties.

Symptoms and Behaviors

The 13/31 code type is associated with the classic conversion V, which occurs when Scale 2 is significantly lower (10 points or more) than Scales 1 or 3. As 2 becomes lower in relation to 1 and 3, the likelihood of a conversion disorder increases. This type of difficulty is strengthened in males who have correspondingly high Scales 4 and 5, and in females with a correspondingly high 4 but lowered 5. However, the 13/31 code type is more frequent in females and the elderly than in males and younger persons. Typically, very little anxiety is experienced by individuals with these profiles because they are converting psychological conflict into physical complaints. This can be checked by looking at the corresponding elevations of Scales 2 and 7. If these are also high, they are experiencing anxiety and depression, perhaps because their conversions are currently unable to effectively eliminate their conflicts. Persons with conversion Vs will typically engage in extensive complaining about physical difficulties. Complaints may involve problems related to eating, such as obesity, nausea, anorexia nervosa, or bulimia; and there may be the presence of vague “neurological” difficulties, such as dizziness, numbness, weakness, and fatigue. There is often a sense of indifference and a marked lack of concern regarding these symptoms. These individuals have a strong need to appear rational and socially acceptable, yet nonetheless control others through histrionic and symptom-related means. They defensively attempt to appear hyper-normal, which is particularly pronounced if the *K* scale is also elevated. Regardless of the actual, original cause of the complaints, a strong need exists to exaggerate them. Even if their complaints were originally caused by an organic impairment, there will be a strong functional basis to their problems.

If Scale 3 is higher than Scale 1, this allows for the expression of a certain degree of optimism, and their complaints will most likely be to the trunk of the body. Thus, patients might complain of difficulties such as gastrointestinal disorders, or diseases of the lungs or heart. Furthermore, a relatively higher 3 suggests the strong use of denial and repression. These people are passive, sociable, and dependent; they manipulate others through complaints about their “medical” problems. Conversely, if Scale 3 is lower than Scale 1, the person tends to be significantly more negative, and any conversion is likely to be to the body extremities such as the hands or legs. If scores are very

high on Scale 8, a corresponding peak on Scale 1 is associated with somatic delusions. Under stress, their symptom-related complaints will usually increase. However, when the stress level decreases, their symptoms will often disappear. The most frequent diagnoses with 13/31 codes are major affective disorders (major depression, dysthymic disorder) hypochondriasis, conversion disorder, passive-aggressive personality, and histrionic personality. Anxiety may be present if either Scale 7 or 8 is also elevated, but these corresponding elevations are rare. The 13/31 profile is also found in pain patients with organic injuries, whose symptoms typically worsen under stress. Malingering of somatic complaints might be indicated if potential gain is a factor and 13/31 is quite high (especially if 3 is above $T = 80$) even if F is not elevated (because they want to emphasize their psychological normality but exaggerate the specifically physical nature of their difficulties).

Personality and Interpersonal Characteristics

Interpersonal relationships will be superficial, with extensive repression of hostility, and often their interactions will have an exhibitionistic flavor. Others describe them as selfish, immature, and egocentric but also as being outgoing, extraverted, and with strong needs for affection. They typically lack insight into their problems, use denial, and will often blame others for their difficulties (check the Repression/ R scale). Usually, they are extremely threatened by any hint that they are unconventional and tend to organize themselves around ideals of service to others. However, their relationships and actual degree of involvement tend to be superficial. They may also feel resentment and hostility toward persons they feel have not provided them with sufficient attention and emotional support. When the conversion V is in the normal range (1 and 3 at or slightly below 65 on the MMPI-2), persons will be optimistic but somewhat immature and tangential. They can be described as responsible, helpful, normal, and sympathetic.

13/31

The 13/31 code type is more common among women and older persons than among men and younger persons. Psychiatric patients with the 13/31 code type usually receive somatoform disorder diagnoses. Classical conversion symptoms may be present, particularly if scale 2 is considerably lower than scales 1 and 3 (i.e., the so-called conversion V pattern). Whereas some tension may be reported by 13/31 persons, severe anxiety and depression usually are absent, as are clearly psychotic symptoms. Rather than being grossly incapacitated in functioning, the 13/31 individual is likely to continue functioning but at a reduced level of efficiency. The somatic complaints presented by 13/31 persons include headaches, chest pain, back pain, and numbness or tremors of the extremities. Eating problems, including anorexia, nausea, vomiting, and obesity, are common. Other physical complaints include weakness, fatigue, dizziness, and sleep disturbance. The physical symptoms increase in times of stress, and often there is clear secondary gain associated with the symptoms.

Individuals with the 13/31 code type present themselves as normal, responsible, and without fault. They make excessive use of denial, projection, and rationalization, and they blame others for their difficulties. They prefer medical explanations for their symptoms, and they lack insight into the psychological factors underlying their symptoms. They manifest an overly optimistic and Pollyannaish view of their situations and of the world in general, and they do not show appropriate concern about their symptoms and problems.

13/31 persons tend to be rather immature, egocentric, and selfish. They are insecure and have a strong need for attention, affection, and sympathy. They are very dependent, but they are uncomfortable with the dependency and experience conflict because of it. Although they are outgoing and socially extroverted, their social relationships tend to be shallow and superficial, and they lack genuine emotional involvement with other people. They tend to exploit social relationships in an attempt to fulfill their own needs. They lack skills in dealing with the opposite sex, and they may be deficient in heterosexual drive.

13/31 individuals harbor resentment and hostility toward other people, particularly those who are perceived as not fulfilling their needs for attention. Most of the time they are overcontrolled and likely to express their negative feelings in indirect, passive ways, but they occasionally lose their tempers and express themselves in angry, but not violent, ways. Behaving in a socially acceptable manner is important to 13/31 persons. They need to convince other people that they are logical and reasonable, and they are conventional and conforming in their attitudes and values.

Because of their unwillingness to acknowledge psychological factors underlying their symptoms, 13/31 persons are difficult to motivate in traditional psychotherapy. They are reluctant to discuss psychological factors that might be related to somatic symptoms, and if therapists insist on doing so, people with this code type are likely to terminate therapy prematurely. Sometimes it is possible to get these persons to discuss problems as long as no direct link to somatic symptoms is suggested. In therapy they expect therapists to provide definite answers and solutions to their problems, and they may terminate therapy when therapists fail to respond to their demands. Because 13/31 persons tend to be suggestible, they often will try activities suggested by their therapists.

13's

The 13 code results from an elevated neurotic triad in which the "conversion valley" pattern is present. It is one of the most frequent two-point combinations, in both normal groups and psychiatric populations. It is more frequent in women; the men who show this pattern often appear clinically feminine. Hathaway and Meehl (1951b) attribute this appearance to the characteristic reliance of these men upon passive methods of handling anxiety and conflicts and to their dependency. The MM PI pattern is often useful in differentiating these men from those in whom feminine personality inversion is a more central problem. Although some of the behavioral characteristics may be similar, the

character structure, dynamics, and prognoses for the two groups are psychologically distinct and separate. From the data presented above on elevation effects and in Chapter 4 on the L-scale effects on code type, it can be deduced that this pattern of MM PI scores is not usually obtained in high-ranging profiles. Rather, it occurs in moderate elevations or in the normal score range. The 13 score combination results from a selective endorsement of somatic items (Hs and Hy-obvious) and denial of social anxiety (Hy-subtle) without endorsement of the depressive and anxiety items that are concentrated primarily in the D and Pt scales. Although there is some psychological contradiction in the admission of some symptoms and problems and the protestation of emotional stability, the pattern of replies basic to this code type does involve a denial of the possibility of mental troubles. The 13s are differentiable from the normal reference group by the frequency and extremity of their denial of troubles or inadequacies. It seems clear, too, that many of the subjects scoring this pattern who do not show manifest emotional difficulties at the time are remaining symptom-free at some considerable effort and cost in emotional control and repression.

Black studied a small but homogeneous group of normal college girls showing either the 13 code or the closely related pattern, 31. These girls were judged by their peers on Black's version of the adjective checklist; they also filled out the same checklist on themselves. The 13-31 group of college women described themselves more frequently as partial, affectionate, and thoughtful than college women in general described themselves. They less frequently labeled themselves orderly, serious, conventional, aggressive, or contented. By and large, these descriptions are safe and innocuous, and form a sharp contrast to the kinds of characteristics their peers ascribed to them. This lack of self-criticism seems consistent with a general impunitive attitude in the way these girls view others, the world, and themselves. Other college women described the 13 girl as selfish and self-centered, with many physical complaints. They said 13s were neurotic, dependent, indecisive, high-strung, and emotional. These girls were also seen as apathetic, eccentric, and secretive, even self-distrusting. In areas of aggression they were seen as hostile, irritable, and lacking in self-control. Although they were termed by their peers serious and idealistic, they were described very infrequently as energetic, enterprising, adaptable, conscientious, or versatile. The 13 girls were also seen as relying upon flattery more frequently than college women generally. Thus, although these girls could not be described as clear-cut psychoneurotics, the personality picture they presented to their acquaintances had many of the features of this psychiatric syndrome. At the college level, Drake reported finding a significant number of 13 codes among his group of counselees who were called aggressive in the interviews held with them when they sought counseling and guidance. Such subjects showed behavior described as defiant, argumentative, cocky, snobbish, aggressive, resistant, opinionated, or belligerent. However, by no means all the subjects showing such behavior had the 13 code on the MMPI, since scales 4 and 9 played an even more important part in the MMPI profiles for this group. L. E. Drake and Oetting (1959) found that men with this code not only showed aggressiveness in their initial

counseling interview, but insisted on knowing the results of their tests and sought definitive answers from the counselors for their problems. They typically appeared free of tensions, restlessness, nervousness, and other signs of acute disturbance. They appeared socially skillful and confident, were fluent and expressive in the interview, and related well to the counselor. In spite of this easy initial relationship, men with this pattern were frequently seen only once, without returns to the center. The women with high 13 profiles who were studied by Drake and Oetting were extroverted, socially outgoing persons, able to verbalize their troubles easily. They reported many conflicts centering around both parents and showed poor academic motivation. They had trouble in examinations from blocking and tightening up. A frequent consideration in such problems was the strong orientation of these women toward marriage. As indicated above, patients showing the 13 pattern are similar in many respects to 12's, Guthrie actually considering them together in his analyses. Hypertension, obesity, and vasomotor instability as well as gastrointestinal distress were the most common presenting complaints of Guthrie's 13 subjects. He found that the 13 subgroup showed less anxiety and tension in their clinical picture than the 12's, depression being virtually absent. However, the 13s did manifest the same general somatic concern common to the whole group. The twenty-three items characteristic of this group (see the Co13 scale in Appendix I in Volume II) were almost entirely somatic items on scales 1 and 3.

Within the psychiatric population, the patients with 13 patterns present problems concerning a variety of physical complaints, but most frequently involving pain. As mentioned above, the 13 patients tend to localize their pains in different parts of the body from the 12 patients. The pains are more frequently in the extremities or the head, rather than in the trunk. If the pain is in the trunk, it tends to be in the upper part, precordial or chest, rather than in the viscera or bowels. These patients complain more frequently of dysfunction of the muscular or central nervous system than of pain in the abdominal region. However, there is also a strong theme in their complaint picture of problems with eating. This may take the form of actual anorexia, or difficulties in appetite, but may also be reflected in nausea or vomiting, or may merely involve overeating. Other complaints that appear frequently are weakness, fatigue, and atypical spells. Conversion hysteria is the modal diagnosis, as reported by Hathaway and Meehl (1951b), for patients with this pattern. Some receive one of several other neurotic diagnoses, and there are a few atypical psychopathic or schizoid cases. Consistent with this diagnostic trend are the findings of Hovey (1949) on somatization reactions, Hanvik (1951) on the functional cases of low back pain, and Sullivan and Welsh (1952) on the psychosomatic ulcer cases they studied. Fricke (1956) reported a mean profile of 31 8247 -569 K-LF? for sixty-three carefully selected female conversion hysteria cases. These patients are characteristically lacking in insight, difficult to get motivated in treatment, and, in marked contrast to most psychiatric patients, frequently extroverted and sociable. In a medical setting, these patients are more typically first seen because of their physical complaints and often resist psychological study or any intimation that their difficulties may stem from emotional problems.

They find physical or organic explanations more acceptable and compatible with their self-concepts than any psychodynamic causes. Halbower's Group III. In the tabulation of 113 cases carried out by Halbower on Veterans Administration cases undergoing treatment in a mental-hygiene clinic, the single largest group of codes was the 13-31s (19 percent). The specific criteria Halbower used in selecting criterion cases for his Code Group III included these: code beginning 13 or 31, with both scales over 70; scale 2 less than scale 3 by at least 10 T-score points; either L or K the highest validity scale, with F no higher than 65; no scales in the code except 1 and 3 over 70. The items which the therapist indicated were characteristic of Code Group III on their Q sorts described this group, like Group I (code 123), as manifesting somatization or psychophysiological reactions. This group was seen as gaining in other ways from these symptoms, however— by getting out of painful or stressful situations. They were characterized as very self-centered and selfish, dependent and demanding in their personal relations, and feeling that they did not get enough consideration from their families. Possibly as a result of this dependency and the resulting frustrations, these patients also seemed to the therapists to be passively aggressive and deficient in heterosexual drive and aggressiveness. The controls the patients employed were externalized ones that tended to involve other people or situations, such as rationalization, blaming others, projection, and acting out. Their self-control was unpredictable, however, and they appeared emotionally labile, easily stimulated, and poorly controlled emotionally. They tended to lose their tempers and blow up under slight provocation. Halbower also found that these patients were relatively free of such psychotic tendencies as depersonalization, strange verbalizations or bizarre mentation, confusions in thought, and feelings of unreality, and of self-criticisms, ruminative introspections, and serious suicidal thoughts. Probably because of these characterological features, in part, and also because they appeared lacking in the ability to develop stable or mature interpersonal relations, these patients were not very frequently considered to be well motivated for intensive psychotherapy. Further analyses of the 13 code groups are reported by Marks and Seeman in their 31-13 pattern and by Gilberstadt and Duker in their 132, 137, 138, and 139 profile types. The defining features of all these patterns are provided in Chapter 3. Carr, Brownsberger, and Rutherford (1966) and Gilberstadt and Jancis (1967) have compared 13 patterns in psychiatric and in medical settings. Their contention is that the higher the elevations on scales 1 and 3 the more likely the case is to be a psychiatric (or functional) problem rather than an organically based difficulty, although the dynamics in the two kinds of manifestations may be quite similar psychologically.

(Dahlstrom, Welsh, & Dahlstrom, 1979)

1-3 See also the 1-3-K combination, p. 89 the 1-3-2 combination, p. 89 the 3-1 combination, p. 126 point 1a for the 1-3-2 Triad profile, Figure 12, p. 134.

1. A person with this combination tends to convert his/her psychological difficulties into physical problems.
2. Pain is a frequent complaint, especially in the extremities (Lachar, 1974).
3. Gastrointestinal problems are common (Carson, 1972). In highly disturbed patients, severe eating problems may be present, such as anorexic vomiting (Drake & Oetting, 1959).
4. This combination is more frequent with women and older persons. Physical symptoms tend to increase in times of stress. People with this combination are very difficult to deal with in psychotherapy because they see their problems as physical in origin, and they expect definite answers to their problems from the therapist (Graham, 1977).
5. The high scale 3 seems to temper the pessimistic complaining attitudes shown by the high 1 scale (Carson, 1969).
6. The lower the 2 scale, so that it is not above 70, the more likely the person has become adapted to his/her physical problems.
7. Elevations on these two scales cannot be used reliably to distinguish functional disorders from actual physical disorders (Schwartz & Krupp, 1971).
8. Marks, Seeman, and Haller (1974) found this 1-3/3-1 pattern in a university hospital and outpatient clinic. This tended to be a female profile. A woman with this pattern usually had a somatic complaint. Her behavior could best be described as agitated, depressed, and confused, with periods of weakness, forgetfulness, and dizziness. The Marks, Seeman, and Haller book should be consulted for further information concerning this pattern.
9. In one sample of psychiatric inpatients, people with a 1-3 pattern showed significantly more somatic concern than other patients (Lewandowski & Graham, 1972).
10. Gynther, Altman, and Sletten (1973) also have found that psychiatric inpatients with this pattern, 1-3/3-1, have an unusual amount of bodily concern.
11. Adolescents in treatment with this 1-3/3-1 pattern (Marks et al., 1974) were referred for treatment because of attention seeking behavior and somatic concern. They saw themselves as physically ill. The Marks, Seeman, and Haller book should be consulted for further information concerning this pattern.
12. Thirty-nine percent of all MMP1 1-3/3-1 patterns in one study had organic diagnoses. Thirty-four percent of all patterns had psychological diagnoses. However, 66 percent of the psychological diagnoses were found in the group members who were under 40. In other words, the older people with 1-3/3-1 patterns in the study tended to have organic problems, whereas the younger people with this pattern had psychological problems (Schwartz, Osborne, & Krupp, 1972).
13. In one study (Long, 1981), patients with this combination did not have successful lower back surgery.
14. Wiltse and Rocchio (1975) have found that for patients treated by chemonucleolysis and laminectomy for low back syndrome, the relative elevations of the 1 and 3 scales on MMPIs administered before the treatment were predictive of successful recovery.

When both scales were 85 or above - 10% had good recovery

When both scales were 75 to 84 - 16% had good recovery

When both scales were 65 to 74 - 39% had good recovery

When both scales were 55 to 64 - 72% had good recovery

When both scales were 54 or below - 90% had good recovery

When patients were high (above 70) on only one of the scales, the patient had a 39% chance of good recovery.

Description:

Neurotic symptoms and somatic concerns, shallow rel-s, narcissistic, resentful, pollyannaish or avoidant of problems and responsibilities, attention seeking, irritable, whining, martyr-complex, passive, suggestable, use repression and denial

Modifying Scales

- When Scale 4 is also elevated, they would tend to be manipulatively demanding, role playing conformity, but subtly acting out. Look for self-defeating impulsive behavior that serves to reduce immediate tension, such as eating disorders or drug or alcohol problems.
- When Scale 2 is elevated, the depression is palpable, though colored by the hysterical denial. The focus is on the physical problems as the cause of depression. The patient will exhibit a smiling depression and will expend energy to please others and stay positive in the face of pain.
- When MacAndrew Alcoholism (MAC-R), Addiction Acknowledgment Scale (AAS), or Addiction Potential Scale (APS) are elevated, they may be using chemical agents as a way of medicating their underlying depression and physical symptoms.
- The Health Concerns (HEA) and Somatic Complaints (BCI) scale will likely be elevated, as with Low Self-Esteem (LSE), suggesting low self-esteem-driven sub-assertiveness.
- The Harris-Lingoes subscales will flesh out the subtle difference in various 1-3 profiles. In most cases, all of the Hysteria (Hy) subscales are elevated, but individuals may also score highly on some of the Psychopathic Deviate (Pd) subscales, reflecting the familial discord that comes from a somatizing and subtly manipulative individual. The HEA component scales can also help to clarify the particular symptoms of concern.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Male

Low 0 One interview only, aggressive or belligerent, wants answers or insists on test scores. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, lack of social skills, mother conflict, being nonresponsive or nonverbal, being nonverbal or a nonrelator, being unrealistic or illogical, nervousness, restlessness, unhappiness.

Female

Low 0 Lacks academic drive, marriage oriented, tense on examinations, socially extroverted.

Low 2 Socially extroverted.

Low 5 Exhaustion, insomnia, headaches, distractible in study, home conflict.

Nothing Low Mother conflict, father conflict, tense on examinations, verbal.

(Drake & Oetting, 1959)

o **Check:** *HEA, RC1, HEA1, HEA2, HEA3, ANX, DEP, DEP1, WRK, Dr3, Dr4, Hy3, Hy4, Sc3, Sc4, Sc6, Hy-O* versus *Hy-S*; *Hy3* versus *Hy4*; and those scales related to the non-somatic features of the Scale 3 syndrome: *CYN1* (low), *CYN2* (low), *RC3* (low), *ASP1* (low), *ASP2* (low), *TPA1* (low), *TPA2* (low), *SOD2* (low), *Hy1*, *Hy2*, *Hy5*, *Ma4*, *Si1* (low), *R*, *O-H*.

TREATMENT

Although these individuals generally are reluctant to talk about possible psychological factors, it may be possible to do so if no direct link is made between their physical symptoms and the current emotional stressors. Clients with this codetype often terminate treatment prematurely if they are pressured to examine their emotional lives without a focus on their fears about physical infirmity. Clients with 13/31 codetypes are highly suggestible, and they expect therapists to provide definite answers and solutions to their physical concerns. Their symptoms can be shaped temporarily by the kinds of medical attention they receive.

Treatment should focus on finishing the mourning process around past losses, helping the client to become acclimatized to the experience of both anger and sadness. Relearning to recognize anger and sadness and finding constructive ways to express them is a productive focus of therapy. Assertiveness training, conflict resolution, and Gestalt therapy, allowing their physical symptoms to do the “talking,” can help them learn to vent their feelings and negotiate their wants. If early parental illness or death occurred, help the client finish grieving. Observe during therapy how being emotionally flooded leads to somatic complaints, perhaps as a way to temporarily shift attention away from emotionally overwhelming material onto potentially soothable physical complaints.

o **Treatment:** May be resistant to insight and psychological approaches. Nonintrospective. Prefers medical explanations for emotional problems. Suggestible. Focused on symptomatic relief. Tolerates support well. Gather recent precipitating events and look for secondary gain and a history of loss. May abuse medications for pain or sleep.

Treatment Implications

Because they lack insight and need to appear hypernormal, they typically make poor candidates for psychotherapy. They prefer simple, concrete answers to their difficulties and avoid introspection. However, they might respond to either direct suggestions or placebos, especially if the placebos are given in a medical context. Interventions such as stress inoculation to reduce their stress might also be helpful. A potentially useful technique is to describe any psychosocial interventions using medical terminology.

Thus, biofeedback or other stress reduction techniques might be referred to as *neurological retraining*. Often, however, they will terminate treatment prematurely, especially if their defenses are challenged. This issue becomes all the more difficult if there is a personality disorder as this would require a lengthier commitment to therapy.

Therapy and Therapeutic Pitfalls

Clients with this profile tend to resist psychological explanations for their symptoms. Often, they have been evaluated by numerous medical specialties without a convincing diagnosis. If they seek psychological help, they're sensitive to being told that their symptoms are "in their head." While brief use of antianxiety medications is useful as a way to reveal to the client the link between anxiety and somatic symptoms, habituation is always a concern.

Clients' symptoms tend to shift and change, shaped by the medical specialty they're involved with. A therapeutic alliance can develop by cataloging clients' medical contacts and helping them to manage the medical system. This serves a supportive role as well as an educational one, teaching the client basic physiology, helping them rule out various diagnoses, and paving the way for the introduction of the mind-body link. Have clients keep a diary to see when symptoms increase or decrease in intensity to help shift the focus to the relationship between psychological stress and physical symptoms. Clients can fill out "Controlling the Focus on Physical Problems" in the *Adult Psychotherapy Homework Planner* (Jongsma, 2006). Therapy needs to be a combination of support, skill building, medical management, insight into how early childhood trauma around illness and loss understandably created in them a panic around subsequent illness and loss, and behavioral techniques for thought stopping and self-soothing. Clients with this profile can respond well to cathartic therapies; however, this type of therapy needs to proceed slowly, as any kind of intense emotional experience tends to lead to physical symptoms such as fainting and dizzy spells. Provide a supportive, safe pace in any kind of emotionally focused therapy to help clients relax, calm their

emotions and thoughts, and learn to self-soothe. Skill building is also important; help clients become more assertive and to recognize when anger and resentment are building.

Therapists involved in the legal system are often tempted to describe the 1-3 individual as having a conversion disorder and therefore malingering and obtaining secondary gain from their symptoms. Recent research (Dreher, 1995; Sommershof et al., 2009) has linked emotional stress with a decrease in the number of killer T cells and a lowered immune system. Labeling these individuals as somehow manipulating the health-care or legal system is simplistic. Their experiences of pain and anxiety are real, and, in some cases, prolonged stress leads to actual physical breakdown.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Treatment and Self-Help Suggestions

1. Keep a diary of your symptoms and a diary of things that stress you during the day. See if there's any link between the two.¹ Learn to recognize when your physical symptoms are increasing, and make a mental note of any stresses that you could be experiencing. Try to deal with the stress and see if the physical symptoms decrease.
2. Relaxation techniques such as mindfulness meditation may help you better manage your response to stressful emotions.² Mindfulness involves paying attention to the present moment in a nonjudgmental way to foster a quality of curiosity and openness. For more information on mindfulness exercises and techniques, see www.mindfulnessstapes.com. Mindfulness classes, books, CDs, DVDs, or tapes can teach you about breathing techniques, patience, and ways to observe your immediate experience without analyzing, judging, or acting prematurely.
3. Practice assertiveness training with your therapist so you can ask for what you want and tell people when you are angry. Some popular, online assertiveness training Web sites can be found at www.helpself.com/directory/assertiveness.
4. Explore with your therapist any childhood experiences where you or a loved one have been ill or in danger of death and how frightening that was for you so that, understandably, you developed this panic about illness and dying. Your therapist may use cognitive-behavioral techniques to help you heal from the trauma of past losses and fears about physical infirmity.³
5. Resilience building: One effective and quick technique to help you with intrusive negative thoughts and worry about your health is called "thought stopping." When you recognize a negative thought or worry, you consciously issue the command, "Stop." Work with your therapist to replace the negative thoughts with something more positive and realistic.

6. Focusing your awareness on unresolved emotions can help shed light on unfinished business. Your therapist may use what is called an “empty chair technique,” which allows you to imagine holding a conversation with someone or something visualized to be in the empty chair. This process can facilitate forgiveness and can help you let go of emotional injuries.⁴

7. Expressive therapies such as art therapy, dance and movement therapy, and creative writing are effective in the treatment of eating disorders. Find a therapist who specializes in experiential or expressive therapy through an eating disorder Web site.⁵

¹ The therapist can use “Controlling the Focus on Physical Problems” in the *Adult Psychotherapy Homework Planner* (Jongsma, 2006).

² Studies suggest that mindfulness-based training is a promising intervention for anxiety and depression (Hofman, Sawyer, Witt, & Oh, 2010).

³ Interventions that have the best empirical support for treating posttraumatic stress disorder are prolonged exposure therapy, and trauma-focused cognitive behavior therapy (Rubin & Springer, 2009).

⁴ Studies comparing emotion-focused therapy (EFT) techniques such as the “empty chair” dialogue to psychoeducational groups revealed greater improvements for depression and global symptoms in the EFT group in the treatment of individuals who were emotionally injured by a significant other (Greenberg, Warwar, & Malcolm, 2008).

⁵ Expressive techniques have been shown to be effective in dealing with the clinical issues that accompany eating disorders: self-esteem, affect modulation, interpersonal relationships, identity issues, and impulse control (Hinz, 2006; Hornyak & Baker, 1989).
(Levak, Siegel, Nichols, & Stolberg, 2011)

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you are a conflict avoider who prides himself on being positive, agreeable, and brave, even when experiencing severe pain and frightening physical symptoms. You like to please others and you work hard to see the best in people. Currently you appear to be experiencing numerous painful and frightening physical symptoms that are the focus of your concern. Stressful events may increase symptoms that are real, but are also linked to the way you deal with emotions. You may not notice the small ways that your body responds when you are stressed, perhaps by hunching your shoulders, holding your breath, clenching your jaw or tensing other muscle groups. Over time, these small physical responses can lead to physical breakdown, so learning not to stress your

body more is a good focus for therapy. You may have learned from an early age, because of some severe loss, to be brave and not allow yourself to become flooded with sadness or anger. Your therapist may want to treat you with some medication and perhaps teach you ways to deal with conflict and stress.

Feedback Statements—Elevated Profiles (T-Score > 65)

Strengths

Your profile reveals a number of strengths. You like to be seen as pleasing and cheerful. You are a peacekeeper who tends to see the best in people.

Somatic Complaints

Your profile suggests that currently you are experiencing a lot of physical symptoms. You may be feeling various aches and pains that shift around your body and come and go. These physical symptoms may be quite frightening to you, and, at times, you may be terrified that something is seriously wrong with you. You may experience symptoms in the head, neck, chest, back, arms, and legs. You may find yourself, at times, experiencing numbness, blurred vision, tingling, eating problems, dizziness, and sleep difficulties.

Weakness or Fatigue

People with your profile often complain of a general sense of weakness. You may find that one or more of your limbs does not work as well as the others, and you may experience periods where you feel weak all over. People with your profile often complain of feeling tired and fatigued, unable to get going, and with low motivation. It may be hard to complete ordinary tasks and activities.

Symptoms Worsen Under Stress

Typically, people with your profile experience their physical symptoms increasing when they are stressed. Also, your worries and fears about your physical problems may become more intense when outside stress increases.

Anxiety and Sometimes Phobias

You feel a pervasive sense of tension and anxiety, fearing that illness is going to strike you at any moment. You may even develop some phobias and specific fears, avoiding situations where you think you may be physically harmed or you may experience an increase in your current physical symptoms.

Overly Responsible and Industrious

People with your profile tend to be quite responsible in spite of feeling a great deal of pain and discomfort. You seem to push yourself hard to accomplish things and to do things that please others. Your profile suggests that you take your duties seriously; even when you are in pain, you likely take care of your responsibilities.

Insecurity

Much of the time, you feel a sense of insecurity and fear that perhaps others are going to abandon you. It's hard for you to trust that others will take care of you and will continue to love you even if you express anger or resentment toward them; you may worry that someone who is angry with you might abandon you.

Overcontrolled

People with your profile work hard to not be angry with others, and you try to stay positive and see the best in people. Normal resentment and anger may become bottled up even though you may not be fully aware of such feelings. When your physical symptoms get worse, it may be related to the stress of controlling your emotions. People with your profile tend to be peacemakers, hating conflict and going the extra mile to avoid it.

Dependent or Passive

When you are preoccupied with your physical illness and your fears of body damage, it's easy to become dependent on others. Others may get irritated with you because you make demands on them and because you want to make sure that your loved ones are close by you in case you need them. Others may also see you as somewhat passive, hanging back and not asserting yourself directly for periods of time. You may avoid taking risks or seeking out new and exciting situations because of your fear that your physical symptoms will become worse.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Conversion V Code

A Conversion V occurs when Scales 1 and 3 are elevated above a *T*-score of 65 and Scale 2 is approximately 8 or more *T*-score points lower than Scales 1 and 3. Persons with Conversion V patterns show strong needs to interpret their psychological or interpersonal problems in ways that are socially acceptable. They deny troubles or inadequacies, and lack the expression of pessimism and depressive feelings seen in the 123/213 codetype. They seem almost indifferent or even jovial, presenting their numerous somatic complaints in a positive, almost cheerful manner. Consequently, this codetype has been described as the "beautiful indifference" or "la belle indifference."

They deny psychological concerns or inadequacies, and the anxiety and depression often found in 13/31 persons without a Conversion V pattern is typically absent. If Scale 9 is distinctly elevated, then the possibility must be considered that manic defenses are being used to ward off depression, and the Conversion V pattern is likely to be somewhat less stable and likely to change when the manic defenses are insufficient for the person to cope.

Many people with Conversion V patterns develop somatic complaints or psychological symptoms of a highly reasonable and socially acceptable type that allow them to displace and externalize inadequacies or problems. They emphasize their somatic symptoms and can discuss their level of pain without the accompanying affect usually associated with people who are experiencing pain. That is not to say that they do not experience genuine pain, but repression and denial are so prevalent and needs for emotional connection are so strong, that pain is expressed with a smile. A within normal-limits conversion profile reveals a socially outgoing person who is cheerfully optimistic, responsible, sympathetic, and over-controlled. These individuals lack insight and are quick to tire and feel poorly under stress.

TREATMENT

See Treatment section under the 13/31 codes.

THERAPEUTIC FEEDBACK LANGUAGE

See Therapeutic feedback language section under the 13/31 codes.

13/31, High K Code

If the K score is also elevated, the 13/31 profile predicts more over-control, inhibition, denial, and need for social acceptance. These individuals have difficulty expressing intense emotions, so the therapist will have to “multiply” the intensity of what they say in order to get a true sense of empathy for them. They are unaware of their negative impulses and emotions and are concerned with being seen as normal, responsible, helpful, and sympathetic. Often their lives are organized around ideals of service to others and contribution to community. They are genuinely caring individuals, uncomfortable with conflict to such a degree that repression of unacceptable impulses may lead to real physical breakdown. They feel judged by any suggestion that they might have psychological difficulties, which they see as a weakness. They do not tolerate the role of psychiatric patient well because they experience genuine physical distress and associated fear, and feel judged by the mental health professional as malingering. Whatever physical symptoms might exist are unlikely to be debilitating, but are the source of great concern (see also Conversion V).

1-3-K

With the 1-3-K combination if the person has had surgery, the individual may have intractable post-operative pain (Caldwell, 1974).

TREATMENT

Although traditional insight psychotherapy is unappealing to these individuals, they can benefit from professional reassurance. Therapists may be tempted to confront patients out of a feeling that they are not doing their job if they are in some way “sympathetic” to the patients’ physical complaints. However, aggressive pushing or confrontation by the therapist will lead to patient termination. The elevation on the *K* scale particularly predicts that the patient will be apprehensive to opening up and experiencing any catharsis. Assertiveness training, emotional support, and helping the client finish grieving about past losses, if done in a gradual manner, could be useful. Real physical breakdown because of the stress placed on their musculoskeletal and organ systems by the inhibition of feelings is a possibility, so relaxation training, yoga, mindfulness therapy, and assertiveness training could help.

- Frequent diagnoses: major affective disorders (major depression, dysthymic disorder), hypochondriasis, conversion disorder, passive-aggressive personality, histrionic personality. High 13/31 occurs among pain patients with organic injuries whose symptoms typically worsen under stress.
Malingering of somatic complaints might be indicated if potential gain is a factor and 13/31 is quite high (especially if 3 is above $T = 80$) even if *F* is not elevated (because patients want to emphasize their psychological normality but exaggerate the specifically physical nature of their difficulties).
(Groth-Marnat, 2009)

THERAPEUTIC FEEDBACK LANGUAGE

Similar to the 13, but be mindful of the patient’s increased discomfort with the exploration of intense feelings suggested by the elevated *K* scale.

132/312 Codes

The addition of Scale 2 as the third highest scale changes some characteristics of the 13/31 codetype. The flagrant manifestation of depression with sad mood, pessimism, and withdrawal is muted by the individual’s need for emotional connection and reassurance, as suggested by the Scale 3 defenses of repression and denial. Consequently, they may be almost cheerful in their presentation, in spite of episodes of tension, distress, and complaints of

weakness and fatigue. Some of these individuals deny any experience of depression, while for others it is more palpable, although explained as caused by physical suffering. Others experience periods of pain remediation, reflecting the interplay between depressive symptoms and hysterical defenses. Personality characteristics of the 13/31 codetype are also present in the 132/312. They are conventional, conforming, anxious to be liked by others, and passive, especially if Scale 4 is low. If Scale 7 is elevated, they are even more conforming, with strong needs for approval and apprehension about conflict.

o “Conversion valley”; usually diagnosed as hysterical neurosis or psychophysiological reaction; classic conversion symptoms may be present; converts stress and difficulties into physical complaints; lacks insight; resists psychological explanations of problems; denial and repression; passive---dependent in relationships; sociable; important to be liked by others; conforming and conventional

1-3-2 See also point l.c. in the 1-3-2 Triad pattern, p. 135.

Gilberstadt and Duker (1965) found this 1-3-2 pattern in a VA hospital male population. Men with this pattern tended to be extroverted, sociable, and highly conforming. Under stress, they tended to develop psychosomatic illnesses. The Gilberstadt and Duker book should be consulted for further information concerning this profile.

1. This is one of two patterns known as the "conversion V" (See the 3-1-2 pattern for the other). For this pattern, scale 1 must be at least 5 T-score points greater than scale 3. The general meaning of the 1-3-2 pattern is that persons with it convert psychological stress and difficulties into physical complaints. The wider the T-score spread between scale 2 and scales 1 and 3, the more severe, long standing, and resistant to change are the physical complaints as shown by the fact that the person is no longer depressed about them.

Figure 13. 1-3-2 Triad Profile.

a. When scales 1 and 3 are above 70 and scale 2 is between 50 and 60 (solid line), people tend to be somewhat pessimistic and complaining. They also may have gastrointestinal complaints. With this pattern, there may or may not be valid physical complaints. The interpretation is that the real or imagined complaints are used to avoid facing up to emotional difficulty. (See also the 1-3 combination, p. 87.)

1-2-3 134

b. When scales 1 and 3 are above 70 and scale 2 is below 45 (dashed line), the interpretation of the pattern is similar to the one provided in the previous paragraph. The primary difference is that the person does not exhibit genuine concern about the physical difficulties. Also existing are more denials of emotional

difficulties, histories of hysteric-like pain which suddenly abates, plus unusual eating patterns. (See also the 1-3-7 profile, p. 90.)

c. When scales 1, 3, and 2 are all above 70 (dotted line), the person can be described as similar to the person discussed in paragraph "a," except that he/she is also depressed. (See the 1-3-2 combination, p. 89.)

1-3-2 (scale 2 T = 45 or Below) See also the 1-3 pattern, and point lb in the 1-3-2 Triad pattern.

1. This person tends to talk a lot about his/her physical complaints, but does not seem to be either depressed or anxious about them (Hovey & Lewis, 1967).
2. This person tends to believe that he/she does not have any emotional problems (Hovey & Lewis, 1967).
3. A history of 11) steric pain which suddenly goes away often is present (Caldwell, 1972).
4. When the K score is also high with this pattern, intractable postoperative pain may exist (Caldwell, 1972).
5. A high incidence of overeating and odd eating habits may be present (Caldwell, 1972).

132/312

This configuration, in which scales 1 and 3 often are significantly higher than scale 2, has been referred to as the "conversion valley." Persons with this code type may show classic conversion symptoms, and diagnoses of conversion disorder or somatoform pain disorder are common. Stress is often converted into physical symptoms. Persons with this code type use denial and repression excessively, lack insight into the causes of their symptoms, and resist psychological explanations of their problems. Although these individuals tend to be rather sociable, they tend to be passive-dependent in relationships. It is important for them to be liked and approved of by others, and their behavior typically is conforming and conventional. They typically are seeking medical treatment for their symptoms and are likely to terminate treatment prematurely if they are pressed to deal with psychological matters.

TREATMENT

With the addition of Scale 2 coded third, patients may be open to hearing how their physical symptoms have "worn them out" and led to an underlying depression, which could be treated with medications. Psychotherapy should focus on how current losses and stresses replicate past childhood losses. In a supportive, nonjudgmental environment, relaxation training, CBT, and even hypnosis could be useful to help manage the symptoms of pain. During relaxation exercises, repressed feelings of anger or sadness could be stimulated, providing an opportunity to deal with past losses. See also the treatment section for the 13/31 codetype.

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you are experiencing many physical symptoms. You may have low energy, feel weak and worn out, and have difficulties with memory and concentration. Sometimes people with your profile have experienced some early losses, such as a death or illness in a parent. You may have learned to be brave and to repress and smile through your sadness in order to not upset others. You dislike conflict and confrontation and your physical symptoms may increase during times of stress. Work on learning to be more assertive and finding ways to relax. Keep a diary of when your physical symptoms increase and see what could be stressing you.

134/314 Codes

Somatic complaints and impulsive, self-defeating tension reduction behaviors characterize this profile. In spite of complaints of infirmity and debilitating physical conditions, these individuals can be opinionated, demanding, argumentative, or belligerent. The addition of an elevated Scale 4 to the 13/31 codetype predicts anger, manipulative dependency, occasional impulsiveness, and emotional distrust. These individuals can manifest some of the characteristics of the 34/43 codetype, such as being explosive and manipulative. They also exhibit other 13/31 codetype characteristics, including a bland indifference toward their symptoms, role-playing for social approval, and numerous physical symptoms, which can be used to manipulate others into satisfying their dependency needs. Fears of abandonment and demands to be taken care of lead to approach-avoidance conflicts in their relations. These individuals lack insight into how they alienate others. Anger tends to be expressed either in episodic outbursts or indirectly, through passive-aggressive means.

- Like *1-3/3-1* but with greater needs for approval. Manipulative, dependent, and fearful of rejection. Potential problems with anger control. See *3-4/4-3, O-H*.
- In one study (Long, 1988), patients with this combination did not have successful lower back surgery.
- Caldwell (1985) has found that when patients have this profile they are more likely to sue their doctors for malpractice

Male

Low 0 Father conflict, one interview only, aggressive or belligerent, wants answers or insists on test scores. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, lack of social skills, mother conflict, being nonresponsive or nonverbal, being nonverbal or a nonrelator, being unrealistic or illogical, nervousness, restlessness, unhappiness.

Female

Low 0 Lacks academic drive, tense on examinations, marriage oriented, home conflict, socially extroverted.

- Note: Scale coded low was infrequently associated with home conflict.

Low 2 Lacks academic drive, home conflict, socially extroverted.

- Note: Scale 2 coded low was infrequently associated with home conflict.

Low 5 Lacks academic drive, distractible in study, home conflict, rebellious toward home, anxieties, exhaustion, insomnia, headaches, indecisive, lacks skills with the opposite sex.

Low 6 Lacks academic drive, vague goals, home conflict.

Low 7/8/9 Lacks academic drive, home conflict.

Nothing Low Lacks academic drive, tense on examinations, home conflict, father conflict, mother conflict, verbal.
(Drake & Oetting, 1959)

TREATMENT

In addition to the therapeutic strategies outlined for the 13/31 codetype, anger recognition and management is critical, so that it is expressed as it builds, rather than being overcontrolled out of fear of rejection and abandonment, and then expressed impulsively. Pay attention to what these individuals deny, as it often is the source of their conflict. Look for childhood experiences of abuse and/or rejection, which may have made them phobic about expressing anger directly toward others. In some cases, this codetype reflects an emotional shutting down, perhaps in response to some profound emotional pain. This leads these individuals to develop a role-playing approach to life whereby they fit into others' role expectations and develop physical symptoms in response to their general overcontrol and bottling up of feelings.

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you are experiencing a great deal of tension and perhaps a number of physical symptoms that make it hard for you to be as productive as others expect. People with your profile often grow up with an explosive or discounting parent figure. You may have learned from an early age to play the right role and to fit in to avoid conflict and rejection. Consequently, you may have difficulty expressing anger, so that it can build up and cause you physical symptoms. Even though you are able to fit in and play the right role, it may be hard for you to trust others, so you might find yourself being manipulative and telling white lies to avoid conflict. Work with your therapist on recognizing when anger is building, learning to express it before it affects you physically.

135 Code

Male

Low 0 Home dependency, four or more conferences (35), one interview only (3-0), aggressive or belligerent, wants answers or insists on test scores.

- Note: Scale 5 coded high was infrequently associated with wanting answers or insisting on test scores. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, lack of social skills, lack of skills with the opposite sex, mother conflict, being nonresponsive or nonverbal, being nonverbal or a nonrelator, being unrealistic or illogical, nervousness, restlessness, tension, unhappiness.

Low 2 Four or more conferences, home dependency.

Low 4 Four or more conferences, home dependency, home conflict.

Low 6/7/8/9 Four or more conferences, home dependency.

Nothing Low Lacks skills with the opposite sex, home conflict, home dependency, four or more conferences, insomnia.

Female

Low 0 Lacks academic drive, marriage oriented, tense on examinations, socially extroverted.

Low 2 Socially extroverted.

Nothing Low Mother conflict, father conflict, distractible in study, tense on examinations, verbal.

- Note: Scale 5 coded high was infrequently associated with father conflict.

(Drake & Oetting, 1959)

136/316 Codes

The addition of Scale 6 to the 13/31 codetype predicts heightened sensitivity to anything that could be construed as criticism or unreasonable demands placed on them by others. These individuals exhibit many characteristics of the 13/31 codetype, but the addition of Scale 6 suggests some characteristics of a 36/63 code, such as paranoid defenses and a tendency to project their anger onto others. These individuals are particularly sensitive to being judged by others as “mentally ill,” so the suggestion that physical symptoms could be psychologically related would be threatening to them. They exhibit a strong sense of pride, a rigid morality, and a tendency to be judgmental of others. They are particularly concerned about their social image and have a strong need to be seen as attractive, conforming, reasonable, and above reproach.

Gastrointestinal problems, headaches, low back pain, and other symptoms are typical, increasing during stressful situations. Despite their physical symptoms, these individuals, particularly men with this profile, are competitive.

Their competitiveness may come from a feeling that they need to be in control of situations as well as somehow having to prove themselves and “be better than others” in order to be above others’ criticisms. Sometimes their need for success and control can lead them to be ruthless, justifying their ambition as a moral crusade. They lack insight into how others see them. Although their anger tends to be overcontrolled, when they feel wronged, they can be particularly focused on seeking “justice.” When Scale 6 is within 8 *T*-score points of Scale 3 and both are elevated significantly above a *T* score of 65, then suspiciousness and abrupt anger reactions will be more marked. If *Pa1* is particularly elevated, hypersensitivity may shade towards overt paranoia. When Scale 3 is higher than Scale 6 by 8 or more *T*-score points, overt paranoid features are less likely and physical complaints will be more prominent. The paranoid traits will be subtler, with a tendency toward unreasonable jealousies and a sensitivity to feeling criticized or unfairly treated, but with a veneer of niceness and socially correct behavior.

o Like *1-3/3-1* but more self-centered, hypersensitive, resentful of demands, and covertly angry and suspicious. See *3-6/6-3*.

Male

Low 0 One interview only, aggressive or belligerent, wants answers or insists on test scores. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, lack of social skills, mother conflict, being nonresponsive or nonverbal, being nonverbal or a nonrelator, being unrealistic or illogical, nervousness, restlessness, unhappiness.

Female

Low 0 Lacks academic drive, tense on examinations, marriage oriented, socially extroverted, resistant in the interview.

Low 2 Socially extroverted.

Low 4 Shy in the interview.

Low 5 Exhaustion, insomnia, headaches, physical inferiority, distractible in study, family conflict.

Nothing Low Mother conflict, father conflict, verbal, 8+ conferences, restless, tense on examinations.

(Drake & Oetting, 1959)

TREATMENT

See also therapeutic strategies outlined for the 13/31 and 36/63 codetypes. These individuals are particularly sensitive to anything that could be construed as criticism or judgment. Before insight and catharsis can develop, these individuals need to feel that the therapist is “on their side.” Explore for childhood histories of criticism or judgment,

with parents' rigid adherence to high moral standards. These individuals tend to internalize their parents' strict values and have difficulty developing empathy for themselves as children who may have been severely punished for minor moral transgressions. As parents, they may replicate their own childhood experiences and be somewhat punitive, moralistic, and rigid with their own children. The primary focus in therapy should be on helping them verbalize their wants directly to others rather than allowing resentments to develop. Help them see how they judge others as a preemptive defense against being judged. Relaxation training and self-esteem building also can be helpful.

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you are a person with very strong morals and values. It is disturbing to you if you perceive people as being immoral or doing the wrong thing. You have very high personal standards and others may see you as being too demanding or critical. Sometimes people who are as perfectionistic as you are develop physical symptoms in response to stress. Headaches, stomach upsets, low back pain, and other vague complaints may increase when you are stressed. Your therapist may want to work on helping you to be less self-critical and recognizing how your physical symptoms are linked to stress. Try to recall moments in your childhood when you felt punished for transgressions and see if you can develop empathy for yourself as a child who wanted to please and do the right thing. Learn to ask for what you want before you are resentful.

137 Code

Severe anxiety, panic attacks, and cardiac complaints such as tachycardia and/or epigastric distress are common with this codetype. Under stress, they develop numerous somatic complaints; although anxiety attacks are the most common, fears and phobias about illnesses are also found. The addition of Scale 7 to the 13/31 codetype adds anxiety, guilt, and profound fears of rejection to an already dependent codetype. These individuals are extremely uncomfortable with conflict and are dependent to the point that they are easily bullied or controlled. They tend to be ingratiatingly subservient. Because of their severe anxiety, these individuals are rigid and adapt poorly to situational changes. Often they are unrealistically insecure about work and finances and depend on a dominant spouse to take responsibility for managing their lives and disciplining the children. Poor vocational adjustment because of anxiety and low self-esteem can occur.

- Like *1-3/3-1* but more anxiety, tension, guilt, and dysphoria. Often phobic. Anxiety may be disabling. Look for cardiac and epigastric complaints, panic attacks; dependent features such as fear of conflict, inhibition of anger, and tolerance for domination. See *1-7/7-1*; *3-7/7-3*.

- Gilberstadt and Duker (1965) found this 1-3-7 pattern in a VA hospital male population. Men with this pattern tended to have severe anxiety attacks and were clinging people. Under stress they developed psychosomatic illnesses. The Gilberstadt and Duker book should be consulted for further information about this profile.

Male

Low 0 One interview only, lacks knowledge or information, aggressive or belligerent, wants answers or insists on test scores. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, lack of social skills, mother conflict, being nonresponsive or nonverbal, being nonverbal or a nonrelator, being unrealistic or illogical, nervousness, restlessness, unhappiness.

Nothing Low Lacks skills with the opposite sex, mother conflict, sibling conflict, nonresponsive or nonverbal, tense, indecisive, unhappy, worries a great deal, insomnia, confused.

- Note: Scale 3 coded high was infrequently associated with mother conflict.

Female

Low 0 Anxieties, insomnia, lacks academic drive, marriage oriented, tense on examinations, socially extroverted.

Low 2 Anxieties, insomnia, socially extroverted.

Low 4 Anxieties, insomnia.

Low 5 Anxieties, insomnia, exhaustion, nervous, headaches, lacks self-confidence, indecisive, distractible in study, family conflict, socially insecure.

- Note: Scale 3 coded high was infrequently associated with social insecurity.

Low 6/8/9 Anxieties, insomnia.

Nothing Low Anxieties, insomnia, headaches, father conflict, mother conflict, sibling conflict, tense on examinations, verbal.

(Drake & Oetting, 1959)

TREATMENT

These individuals can be best understood by thinking of them as panicked, dependent children. Because they are agreeable and ingratiating, they can be likable. However, they can exhaust the therapist because of their constant need for reassurance, which has only a transitory effect on lowering their anxiety. If they perceive the therapist as impatient or angry, they become more anxious and demanding of reassurance. Look for childhood histories of unpredictably explosive and/or rejecting parents or situations. The profile reflects an individual who is constantly on

guard against the onset of unpredictable, overwhelming emotional and/or physical pain. Look for traumatic experiences in which they feared for their lives, and use deconditioning therapies, such as systematic desensitization and implosion therapies, to lower their anxiety. Help them develop self-soothing strategies. Assertiveness training, relaxation training, and reparenting of their inner terrified child can be helpful.

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you tend to worry and experience a great deal of anxiety. You may experience fears, phobias, anxiety attacks, and panics about your health. You dislike conflict and confrontation, so others can bully and dominate you. Perhaps you experienced unpredictable, even terrifying, events that have left you constantly on edge, wanting to make sure you don't get taken by surprise again. Perhaps you experienced an unpredictably angry or rejecting authority figure, so you go out of your way to avoid others being angry with you now. Your physical symptoms may increase during times of stress. Relaxation training and assertiveness training can help you, as well as learning to switch off panicked thoughts and be more assertive.

138/318 Codes

(see also 1382 Code)

These individuals tend to have eccentric, unusual ideas and beliefs, particularly about religious and sexual topics, as well as numerous vague and bizarre somatic complaints. One example was a young woman from an upper socioeconomic background who was preoccupied with mold and had inhabited and left nine rented homes in succession, each after a brief stay, convinced she was suffering from its effects in every home. Numerous legal actions against her for breaking her leases and her countersuits for mold damages were the focus of her life. She would come to her therapy appointments with boxes of documents, neatly stapled, to substantiate her claims. She appeared logical, rational, and coherent, except for the fact that her preoccupations were bizarre and medical diagnosis had failed to find a cause for her shifting symptoms. Tremors, amnesia, blurred vision, dizziness, fainting spells, blackouts, and vague tinglings and numbnesses are often associated with neurological impairment, so 138 individuals exhaust medical diagnostic testing before being referred to a psychologist. This is an intuitively odd codetype in that it mixes both neurotic and schizoid, psychotic elements. It reflects a classical approach avoidance conflict, with high Scale 3 needs for closeness and reassurance reflecting the approach side and high Scale 8's fear of intimacy and need for self-protective distancing, the avoidance side. The hypochondriacal complaints may act as an "anchor," grounding the individual in realistic and care-eliciting concerns, preventing the disintegration into

more floridly psychotic symptoms. These individuals are quite changeable both in their moods and in their belief systems, and are therefore sometimes misdiagnosed as bipolar. When threatened, some may experience brief psychotic episodes or bizarre, loose associations that disappear once the threat is removed. Religiosity, sometimes mixed with sexuality and religious delusions, may be present. The religious preoccupations may represent a defense against the diffuse anxiety and panic associated with Scale 8, providing inner structure and meaning as a defense against the experience of anhedonia.

These individuals have difficulty concentrating. Their responses to open-ended questions tend to be confused, with loose associations, and their conversation appears oddly connected and is hard to follow. Childhood histories often show a family history of psychosis and/or severe emotional deprivation and abuse. These individuals function best in structured situations, and bizarre, confusing symptoms may increase when structure is absent. They tend to have unusual sex histories with poor childhood boundaries and sex abuse, so they are often sexually preoccupied but naive and inhibited.

o Like *1-3/3-1* but with far greater emphasis on cognitive, sensory, musculoskeletal, and neurological symptoms (e.g., dizziness, tremor, blurred vision, amnesia). Depressed, with suicidal ideation; fearful, tense, possibly withdrawn. Look for paranoid/schizotypal features, religious and sexual content, and sexual identity issues.

138

Persons with this code type usually are diagnosed with schizophrenic disorder (paranoid type) or paranoid personality disorder. They are likely to have rather bizarre somatic symptoms that may be delusional in nature. Depressive episodes, suicidal ideation, and sexual and religious preoccupation may occur. Clear evidence of thought disorder may be observed. These individuals are agitated, excitable, loud, and short-tempered. They often have histories of excessive use of alcohol and feel restless and bored much of the time. They are ambivalent about forming close relationships, and they often feel suspicious and jealous.

o Usually diagnosed as paranoid schizophrenic or paranoid personality; agitated, excitable, loud, short--- tempered; depressive spells and suicidal preoccupation; somatic symptoms may be delusional in nature; sexual and religious preoccupation; thinking disturbance and blocking; excessive drinking; ambivalent feelings toward others; suspicious, jealous; restless, bored

1. A person with this profile tends to have strange ideas and/or bizarre sexual and religious beliefs. He/she often may be depressed and changeable (Caldwell, 1972).
2. Usually a family background of psychosis and/or childhood deprivation exist (Caldwell, 1972).
3. This type of person seems to need structure. He/she tends to do well in school when the school is structured. However, when this structure or a significant relationship is gone, bizarre symptoms may be seen (Caldwell, 1972).
4. Gilberstadt and Duker (1965) found this 1-3-8(2) pattern in a VA hospital male population. The 2 scale is elevated above 70, but it is not necessarily the next highest scale after the 8. Men with this pattern tended to have confused thinking, suspiciousness, and jealousy. These researchers hypothesize that these men may have somatic illnesses to defend against their schizophrenic tendencies. The Gilberstadt and Duker book should be consulted for further information concerning this profile.

Description:

Possible somatic delusions, depression, suicidal ideation, religious or sexual preoccupation, loud, angry, anxious, restless

Possible Diagnoses:

Paranoid schizophrenia

Male

Low 0 One interview only, lacks knowledge or information, aggressive or belligerent, wants answers or insists on test scores. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, lack of social skills, mother conflict, being nonresponsive or nonverbal, being nonverbal or a nonrelator, being unrealistic or illogical, nervousness, restlessness, unhappiness.

Low 2/4/5/6/7 Lacks knowledge or information.

Low 9 Introverted or self-conscious or socially insecure, lacks knowledge or information.

Nothing Low Indecisive, unhappy, worries a great deal, insomnia, lacks knowledge or information, confused.

Female

Low 0 Verbal, lacks academic drive, marriage oriented, tense on examinations, socially extroverted.

Low 2 Verbal, socially extroverted.

Low 4 Verbal.

Low 5 Verbal, anxieties, exhaustion, insomnia, headaches, distractible in study, home conflict.

Low 6/7/9 Verbal.

Nothing Low Verbal, 8+ conferences, depressed, father conflict, mother conflict, sibling conflict, tense on examinations, lacks skills with the opposite sex.

(Drake & Oetting, 1959)

o **Check:** *Dr4, CogProb, Hy4, Sc3, Sc6, HEA2. See 1-8/8-1; 3-8/8-3.*

TREATMENT

Individuals with this codetype typically have severely disturbed family histories and many unresolved dependency needs. As elevations on Scale 3 would predict, they have strong needs for reassurance and closeness, but also experience great fears of rejection and closeness. Their tendency toward loose associations could be a barometer for how stressful particular avenues of psychotherapy are becoming. Therapy should be highly structured and proceed slowly. Reparenting supportive therapy in a highly structured situation would be most useful. If sexuality is explored in therapy, it should be within even more structure than typical in order to minimize transference and counter-transference.

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you may be experiencing many physical symptoms that have been difficult to diagnose because they seem to shift and change over time. You probably spend a great deal of time and concern trying to determine what is wrong. You are a sensitive person, and are uncomfortable with conflict, so when you get stressed your thinking may be affected. At these times, it may be hard for you to get your thoughts out and have people understand you. You may have grown up in an environment that often felt unsafe and frightening, and you adapted by trying to stay positive and escape into your own world. Now, when you are stressed, some of your physical symptoms may increase. Relaxation training and thought stopping when your mind runs away from you can help. When you know you might become stressed, write things down you want to get across to others beforehand, so your thoughts stay clear.

1382 Code

In addition to the 138/318 codetype interpretation, depression, confused thinking, heavy drinking, and suicidal preoccupation are also likely. Social adjustment is poor and relationship problems are recurrent. Work history is also erratic, with numerous absences due to illness and stress related disorders.

1-3-8-2 See the 1-34 pattern, point 4, above.

TREATMENT

See treatment section under the 138/318 Code. A mixture of somatic, psychotic, hysterical, and depressive traits and symptoms manifests itself in different ways so that the depression may be expressed somatically, with loose associations masked by the somatic delusions that appear initially to have coherence. Whichever complaints and symptoms are most prominent and debilitating should be dealt with initially, dealing with the symptoms step by step. Antidepressant and anti-anxiety medications could be useful in conjunction with a reparenting supportive type of therapy, providing structure and assertiveness training as well as self-esteem building. Energizing antidepressants should be used cautiously, as they may increase cognitive disorganization.

THERAPEUTIC FEEDBACK LANGUAGE

See suggested 138 feedback language. Add: Your profile also suggests that you have periods where you feel sad, unhappy, and down. At these times it may be even harder to make decisions, recall important events, concentrate, and think clearly. Your doctor may consider medicine to help you sleep better, feel more efficient, think more clearly, and feel less down.

139 Code

Highly driven for attention and approval, these individuals tend to lack self-awareness and are surgent, opinionated, and preoccupied with physical symptoms and disabilities. They are performers and approval seekers, often exhibiting manic or hypomanic overcommitment and grandiosity. They have difficulty expressing anger in a modulated way, showing irritability, good-natured humor, hostile criticism, and explosive episodes in close proximity. After they have exploded, they tend to deny or repress the importance of the explosive episode and go back to temporary cheerful denial. Numerous somatic complaints are present, such as headaches, auditory and visual complaints, tremors, coordination difficulties, and other vague and shifting complaints. They lack selfawareness

and become defensive at any criticism. They exhibit low frustration tolerance, irritability, and temper outbursts, often becoming combative or destructive (particularly if Scale 4 is also elevated and/or if *K* is low). Their agitated intensity and sudden mood shifts have been associated with an organic brain disorder, so a neurological etiology should be ruled out. Interpersonal relations are stormy, and divorces are frequent. They are often seen as very demanding of their families and, although wanting approval and affection, they have difficulty expressing it to

others. Disinhibiting agents such as alcohol can lead to impulsive aggression and subsequent amnesia around the episode. This codetype is associated most often with personality disorders or with brain syndromes associated with trauma.

139

Persons with this code type often are diagnosed as having a somatoform disorder or organic brain syndrome. If they are given the latter diagnosis, they may show spells of irritation, assaultiveness, and outbursts of temper.

o Like *1-3/3-1* but with more activity, energy, self-confidence, and social fearlessness and aggression. Lower emotional and behavioral inhibition. Look for high needs for approval, demandingness, frustration intolerance, irritability, acting out, narcissism, grandiosity, deceitfulness, and manipulations leading to family conflict. Consider neuropsychological evaluation.

- o May be diagnosed as chronic brain syndrome or conversion reaction; if “cbs” may have spells of irritation, temper outbursts, and assaultiveness
- Gilberstadt and Duker (1965) found this 1-3-9 pattern in a VA hospital male population. Men with this pattern tended to have chronic organic illnesses, frequently with organic brain dysfunction. Temper outbursts were seen at times, and occasionally these people became combative and disruptive. The Gilberstadt and Duker book should be consulted for further information concerning this pattern.

Description:

Impulsive, spells of aggressiveness, might have organic brain damage

Possible Diagnoses:

Somatoform disorder, brain damage

Male

Low 0 One interview only, aggressive or belligerent, wants answers or insists on test scores. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, shyness in the interview, lack of

social skills, mother conflict, being nonresponsive or nonverbal, being nonverbal or a nonrelator, being unrealistic or illogical, nervousness, restlessness, indecisiveness, unhappiness.

Low 6 Rationalizes a great deal.

Female

Low 0 Marriage oriented, tense on examinations, lacks academic drive, socially extroverted, verbal.

Low 2 Marriage oriented, socially extroverted.

Low 4 Marriage oriented, socially extroverted, shy in the interview, nonresponsive.

- Note: Scale 3 coded high was infrequently associated with nonresponsiveness.

Low 5 Marriage oriented, distractible in study, socially extroverted, exhaustion, insomnia, headaches, home conflict, verbal.

Low 6/7/8 Marriage oriented, socially extroverted.

Nothing Low Marriage oriented, tense on examinations, socially extroverted, father conflict, mother conflict, verbal
(Drake & Oetting, 1959)

o **Check:** *Dr3, Dr4, Hy4, Pd3, Sc3, Sc6, HEA2, Ma4, DISC*. See 1-9/9-1; 3-9/9-3.

TREATMENT

Look for a family history of domineering parents whose approval was dependent on performance. These individuals often internalize parental expectations and values, although resenting their control. Their physical symptoms reflect their over-control, combined with high energy, need for constant stimulation, and lack of self-awareness around negative emotions. Because of their need for approval, they respond well to supportive, approving therapists who can help them distinguish their own wants versus the internalized expectations of their parents. Help them realize how their strong needs for approval lead to feeling controlled and dominated by those from whom they seek approval. This dynamic replicates their experiences with their parents. Help them learn to recognize when anger and irritability are building, and help them to rehearse ways of expressing it so that negative emotions do not build, leading to explosive episodes. Exercise, mindfulness training, and insight therapy around self-esteem can be useful.

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests you are a very driven and energetic individual who operates on two speeds: “full on” or off.

You tend to be very demanding of yourself and others and you may overcommit to too many tasks and activities.

You can be cheerful, humorous, and take charge easily, often expressing your opinions forcefully, but when you feel

people are in your way or slowing you down you can become quite irritable, sometimes even loud and critical. It's difficult having high energy in a world you experience as moving too slowly. You may experience numerous physical symptoms that ebb and flow, depending on your level of tension and frustration. Headaches, stomach aches, numbnesses and tinglings, dizzy spells, even fainting spells have all been associated with this profile. Learning to recognize when stress is building, and relieving it through exercise as well as learning how to express anger in a non-combative way could be useful strategies in therapy. You may have grown up feeling a great deal of pressure to perform and achieve in order to experience self-esteem and you may want to discuss with your therapist what your real goals are versus what you feel you need to achieve in order to obtain others' approval.

14/41 Codes

This is a relatively rare codetype. The primary complaints tend to be somatic rather than psychopathic. Scale 1 correlates reduce the aggressive acting out usually associated with Scale 4 elevations. Rather, the acting out is manifested as manipulative dependency, with a tendency to manipulate others through physical illnesses. The addition of Scale 4 to Scale 1 aggravates the cynicism, bitterness, and pessimism already manifested by the elevation of Scale 1. These individuals are dependent and, at the same time, distrustful that others will care for them. A history of poor social adjustment and a resistance to rules, regulations, or restrictions is typical. "I'm sick and fed up, therefore the rules don't apply to me" would be a way to characterize their view of life. They tend to be negative, complaining, self-pitying, and easily upset when their immediate needs are not met. They approach life with a "who is going to help me today?" attitude centered on their physical illnesses and disabilities. They feel entitled because they are suffering and are highly dependent, although they simultaneously anticipate being let down and emotionally abandoned. Since they don't trust others to take care of them, their negativity manifests itself as stubbornness and passive resistance to being controlled.

Their self-centered and demanding style, accompanied by physical complaints such as headaches and pain, makes adaptive sense for someone who is fearful of abandonment and in physical pain. Complaints of depression and anxiety as a result of their physical symptoms are associated with feelings of being defeated and helpless rather than a sense of communicative sadness.

They often exhibit socially unacceptable behavior and inadequacy in meeting the usual stresses and responsibilities of life. Excessive alcohol use or other self-soothing addictions can also be present. They have difficulty with self-discipline and decision

making and exhibit poorly defined goals. They have difficulties in establishing enduring relations with members of the opposite gender. Tension, turmoil, and chronic complaining characterize family relations.

The most common three-point codetypes are 143/413 and 142/412. When Scale 3 is also elevated, manipulative role-playing and need for social approval are present. Family and marital problems are suggested. These individuals want approval and connectedness but fear abandonment, so they give very mixed messages to loved ones. The presence of Scale 3 predicts overcontrol, a tendency to mask the hostility and alienation suggested by Scale 4, and an increased likelihood that the physical symptoms reflect the overcontrol of negative impulses. Usually such code patterns show an elevated *O-H* scale.

- Emphasis on gastrointestinal symptoms not infrequently associated with alcohol abuse. Other somatic complaints and health concerns are common. Discontent and dysphoric. Very intolerant of stress; fears of disability. Immature and dependent (hostile dependency).
- Family estrangement and generally poor relations with others, with control avoidance, acting out, self-centeredness, entitlement, aggressiveness or passive aggression, grouchiness, dissatisfaction, demandingness, stubbornness, controllingness, complaining, blaming, bitterness, and conflict. Look for a history of drug-seeking, irresponsibility, delinquency, authority conflicts, employment instability, marital conflict, and arrests.
- Severe hypochondriacal symptoms, especially nonspecific headaches; indecisive, anxious; socially extraverted but lacks skills with opposite sex; feels rebellious toward home and parents but doesn't express these feelings; excessive use of alcohol likely; lacks drive; poorly defined goals; dissatisfied, pessimistic; demanding, grouchy, bitchy; resistant to traditional psychotherapy
- This combination is not found frequently, but when present is more likely a male's profile rather than a female's. There may be severe hypochondriacal symptoms, especially headaches. People with this combination may be rebellious but not express this directly (Graham, 1977).
- The person may be pessimistic, grouchy, bitchy, and dissatisfied (Lachar, 1974).
- Gynther, Altman, and Sletten (1973) have found that psychiatric inpatients with this pattern, 1-4/4-1, may have a drinking problem. These researchers found almost no females with this pattern.

- Adolescents in treatment with the 1-4/4-1 pattern (Marks et al., 1974) were referred, typically by the courts because they were de-fiant, disobedient, and impulsive. They were seen as aggressive, outspoken, resentful, and self-centered. The Marks, Seeman, and Haller book should be consulted for further information about this profile.

Symptoms and Behaviors

The 14/41 code is encountered somewhat rarely, but is important because persons with these elevations will be severely hypochondriacal. They will be egocentric, will demand attention, and will express continuous concern with their physical complaints.

There will be some similarities to other high-scoring 4s in that these individuals may have a history of alcohol abuse, drug addiction, and poor work and personal relationships

(check WRK/Work Interference, MAC-R/MacAndrew Alcoholism scale, APS/Addiction Potential scale, and AAS/Addiction Acknowledgment scale) to refine interpretations). They may also be indecisive and rebellious.

The two most frequently encountered diagnoses will be hypochondriasis and a personality disorder, especially antisocial personality. Differentiation between these two can be aided by noting the relative strength of either Scale 1 or 4, as well as other related scales. Profiles involving “neurotic” features (anxiety, somatoform, dissociative, and dysthymic disorders) are characterized by a relatively higher Scale 1 with 2 and/or 3 also elevated. Personality disorders are more strongly suggested when Scale 4 is the primary high point.

Personality and Interpersonal Characteristics

A core feature of this code type is likely to be ongoing personality difficulties. They are likely to act out and use poor judgment. Interpersonal interactions will be extremely manipulative but rarely will they be extremely antisocial.

They might feel a sense of rebelliousness toward their homes and parents although these feelings are not likely to be expressed openly. Although they will be able to maintain control over their impulses, they will do so in a way that is bitter, pessimistic, self-pitying, and resentful of any rules and limits that are imposed on them. They are likely to be described by others as demanding, grouchy, and dissatisfied (check the CYN/Cynicism, ASP/Antisocial Practices, and FAM/Family Problems scales).

- This combination is not found frequently, but when present is more likely a male's profile rather than a female's. There may be severe hypochondriacal symptoms, especially headaches. People with this combination may be rebellious but not express this directly (Graham, 1977).
- The person may be pessimistic, grouchy, bitchy, and dissatisfied (Lachar, 1974).

- Gynther, Altman, and Sletten (1973) have found that psychiatric inpatients with this pattern, 1-4/4-1, may have a drinking problem. These researchers found almost no females with this pattern.
- Adolescents in treatment with the 1-4/4-1 pattern (Marks et al., 1974) were referred, typically by the courts because they were defiant, disobedient, and impulsive. They were seen as aggressive, outspoken, resentful, and self-centered. The Marks, Seeman, and Haller book should be consulted for further information about this profile.

14/41

The 14/41 code type is not encountered frequently in clinical practice and is much more likely to be found for men than for women. Persons with the 14/41 code type frequently report severe somatic symptoms, particularly nonspecific headaches. They also may appear to be indecisive and anxious. Although they are socially extroverted, they lack skills with members of the opposite sex. They may feel rebellious toward home and parents, but direct expression of these feelings is not likely. Excessive use of alcohol may be a problem, and 14/41 persons may have a history of alcoholic benders, job loss, and family problems associated with their drinking behavior. In school or on the job, 14/41 persons lack drive and do not have well-defined goals. They are dissatisfied and pessimistic in their outlook toward life, and they are demanding, grouchy, and referred to as "bitchy" in interpersonal relationships. Because they are likely to deny psychological problems, they tend to be resistant to traditional psychotherapy

Description:

More common in men, problems in meeting responsibilities, self-pity, antiauthoritarian attitudes, somatization, narcissism, alcohol problems, vocational and interpersonal problems

Possible Diagnoses:

Hypochondriasis, Social phobia, Chronic alcohol intoxication, Substance abuse, Somatization, Affective disorder

Male

Low 0 Father conflict, aggressive or belligerent

Female

Low 0 Lacks academic drive, socially extroverted.

Low 2 Socially extroverted.

Low 5 Anxieties, headaches, rebellious toward home, indecisive, lacks skills with the opposite sex.

Low 6 Vague goals.

(Drake & Oetting, 1959)

o **Check:** *HEA, RC1, HEA1, HEA2, HEA3, DEP, DEP1, ASP2, FAM2, WRK, Dr3, Dr4, Hy3, Hy4, Pd1, Pd2, Pd4, Pd5, Pa1, Sc3, Sc4, Sc6, Re (low), RC4, MAC-R, AAS.*

TREATMENT

Although they may show a good response to short-term symptomatic treatment, individuals with 14/41 codetypes tend not to stay in treatment long enough to make significant personality changes because they resist demands placed on them by the therapist. They tend to be demandingly dependent individuals who want to be taken care of, but at the same time are angry and distrustful. These feelings tend to be expressed passively rather than overtly. Their tendency is to approach the therapist with a “what are you going to offer me today that probably won’t work?” attitude because they see themselves as suffering and immobilized by their physical ailments. They feel in need of relief and are angry when they do not experience it. Treatment can focus on their tendency to distrust that others really care and, consequently, to feel that they must manipulate others into taking care of them. They want to be taken care of, but are angry, anticipate abandonment, and feel justified in manipulating others as the only way they can get their needs met. Look for early childhood histories of emotional letdowns and abandonment that conditioned in them a basic mistrust. Sometimes this occurs in the context of a history of illness in themselves or in someone they were dependent on. Conceptually, this codetype reflects an immature, dependent individual who psychologically is “very young.” They need to learn self-efficacy. Family therapy combined with nurturing limit setting by the therapist, and teaching loved ones how to be supportive, but not co-dependent, can be helpful. Mindfulness classes and gentle exercise can be helpful.

o **Treatment:** May be resistant to insight and psychological approaches. Poorly motivated to change. Prone to authority conflicts with therapist and unreliability in the reporting of history and events.

- Frequent diagnoses: hypochondriasis, personality disorder (especially antisocial personality); relatively higher 4 suggests antisocial personality; relatively higher 1 suggests hypochondriasis. Profiles involving “neurotic” features (anxiety, somatoform, dissociative, and dysthymic disorders) will have relatively higher Scale 1 with 2 and/or 3.
(Groth-Marnat, 2009)

Treatment Implications.

Usually, 14/41 patients will be resistant to therapy, although they may have a satisfactory response to short-term, symptom-oriented treatment. However, long-term therapy will be difficult and characterized by sporadic participation. Sessions may become somewhat tense because of their level of resentment and hostility, which is likely to be sometimes expressed toward the therapist (check the TRT/Negative Treatment Indicators and ANG/Anger scales).

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you are experiencing many physical symptoms that interfere with you being able to enjoy life and accomplish physical jobs and activities. You likely want loved ones to care for you, but at the same time you may be afraid to trust that they will be there for you when you need them. You may feel that you have to be a survivor, relying on manipulating those around you in order to obtain the care you need. Sometimes people like you came from a background where they felt emotionally abandoned and unable to trust authority figures to take care of them. Perhaps you were ill often and received care and special attention only when you were very sick. Now you feel dependent on others and are often impatient and irritated with how they treat you. Explore your childhood with your therapist to determine why you learned to be a survivor. Be mindful to not be manipulative with others because they will lose trust in you. Take a mindfulness class to be aware of your own and others' feelings and take time to ask others about how they are feeling. When your physical symptoms increase in intensity, don't soothe yourself with bad habits, food, or chemicals. Use deep breathing and relaxation exercises as a way to reduce stress.

145 Code

Male

Low 0 Father conflict, worries a great deal, aggressive or belligerent.

- Note: Scale coded low was infrequently associated with worrying a great deal.

Low 2/3/5/7/8/9/Nothing Low Worries a great deal.

Female

Low 0 Lacks academic drive, socially extroverted.

Low 2 Socially extroverted.

Low 6 Vague goals.

Nothing Low Distractible in study.

(Drake & Oetting, 1959)

146 Code

Female

Low 0 Lacks academic drive, socially extroverted, resistant in the interview.

Low 2 Socially extroverted.

Low 5 Physical inferiority, indecisive, anxieties, headaches, lacks skills with the opposite sex, rebellious toward home.

Nothing Low Restless, 8+ conferences.

147 Code

Male

Low 0 Home conflict, father conflict, one interview only, lacks knowledge or information, aggressive or belligerent.

Low 2/3/5/6/8/9 Home conflict.

Nothing Low Lacks skills with the opposite sex, home conflict, mother conflict, sibling conflict, nonresponsive or nonverbal, tense, indecisive, unhappy, worries a great deal, insomnia, confused, poor rapport.

- Note: Scale 4 coded high was infrequently associated with lack of skills with the opposite sex

Female

Low 0 Insomnia, rebellious toward home, lacks academic drive, socially extroverted.

Low 2 Insomnia, rebellious toward home, socially extroverted.

Low 3 Insomnia, rebellious toward home, cried in the interview.

Low 5 Insomnia, headaches, exhaustion, nervous, anxieties, rebellious toward home, indecisive, socially insecure, lacks skills with the opposite sex, lacks self-confidence.

- Note: Scale 4 coded high was infrequently associated with social insecurity.

Low 6 Insomnia, rebellious toward home, vague goals.

Low 8/9 Insomnia, rebellious toward home.

Nothing Low Insomnia, headaches, rebellious toward home, sibling conflict, tense on examinations.

(Drake & Oetting, 1959)

148 Code

Male

Low 0 Father conflict, lacks knowledge or information, aggressive or belligerent.

Low 9 Introverted or self-conscious or socially insecure.

Nothing Low Indecisive, unhappy, worries a great deal, insomnia, confused.

Female

Low 0 Insomnia, depressed, overprotective mother, verbal, lacks academic drive, socially extroverted.

- Note: Scale coded low was infrequently associated with depression.

Low 2 Insomnia, depressed, overprotective mother, socially extroverted.

Low 3 Insomnia, depressed, overprotective mother.

Low 5 Insomnia, depressed, anxieties, headaches, overprotective mother, rebellious toward home, distractible in study, lacks skills with the opposite sex, indecisive.

Low 6 Insomnia, depressed, overprotective mother, vague goals.

Low 7/9 Insomnia, depressed, overprotective mother.

Nothing Low Insomnia, depressed, headaches, overprotective mother, mother conflict, father conflict, sibling conflict, 8+ conferences, lacks skills with the opposite sex.

(Drake & Oetting, 1959)

149 code

Male

Low 0 Father conflict, aggressive or belligerent. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, shyness in the interview, being nonresponsive or nonverbal, being nonverbal or a nonrelator, indecisiveness.

Low 2 Aggressive or belligerent.

Low 6 Rationalizes a great deal.

Female

Low 0 Socially extroverted, vague goals, marriage oriented, lacks academic drive, verbal, home conflict.

- Note: Scale coded low was infrequently associated with home conflict.

Low 2 Socially extroverted, vague goals, verbal, home conflict.

- Note: Scale 2 coded low was infrequently associated with home conflict.

Low 3 Socially extroverted, vague goals, verbal, home conflict.

Low 5 Socially extroverted, vague goals, verbal, home conflict, exhaustion, headaches, anxieties, rebellious toward home, indecisive.

Low 6/7/8/Nothing Socially extroverted, vague goals, verbal, home conflict.

(Drake & Oetting, 1959)

15/51 Codes

(see also Scales 1 and 5)

This is an uncommon codetype for men and an extremely rare code for women. Most commonly, Scale 3, 4, or 2 is the third highest scale for men. Men with this code usually are fussy, sensitive, complaining, and passive. Somatic complaints predominate. Acting out is rare and seldom do they engage in open conflict or disagreement. Usually they are of above-average intelligence, are interested in cultural, verbal, and aesthetic pursuits and are upper SES. In women, this uncommon codetype suggests both somatic complaints and anxieties and a self-sufficiency and assertiveness, which appear paradoxical. Scale 1 attributes such as health pessimism and immaturity coexist with interpersonal competitiveness and practical, outdoor, action-oriented activities. Sometimes women with this codetype can be emotionally domineering in their relations with others. For both men and women, this codetype is associated with multiple surgeries.

- Men: (Uncommon) Passive, dependent, complaining, fussy; avoidant of responsibilities; rationalizing. Check third highest scale.
- Women: (Rare) Complaining, coarse, mistrustful, insensitive. Mild anxiety and apprehensiveness. Check third highest scale.
- Men with this pattern may have passivity, and a fussy, complaining attitude (Lachar, 1974).
- For men, this combination may suggest multiple surgeries. For women, the 1-5 would also suggest the same (Trimboli & Kilgore, 1983).
- Adolescents in treatment with this 1-5/S-I pattern (Marks et al., 1974) were referred because of their hyperactivity. They tended to be impulsive and effeminate. They presented themselves as physically ill and had had significant amounts of illness as children. The Marks, Seeman, and Haller book should be consulted for further information concerning this pattern.
- Men with this pattern may have passivity, and a fussy, complaining attitude (Lachar, 1974).

- For men, this combination may suggest multiple surgeries. For women, the 1-5 would also suggest the same (Trimboli & Kilgore, 1983).
- Adolescents in treatment with this 1-5/S-I pattern (Marks et al., 1974) were referred because of their hyperactivity. They tended to be impulsive and effeminate. They presented themselves as physically ill and had had significant amounts of illness as children. The Marks, Seeman, and Haller book should be consulted for further information concerning this pattern.

Male

Low 0 Home dependency. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, lack of skills with the opposite sex, being nonresponsive or nonverbal, tension.

Low 2/3 Home dependency.

Low 4 Home dependency, home conflict.

Low 6/7/8/9 Home dependency.

Nothing Low Home dependency, home conflict, insomnia.

Female

Low 0 Socially extroverted.

Nothing Low Distractible in study.

(Drake & Oetting, 1959)

TREATMENT

Assertiveness training and catharsis can be useful treatment modalities for men. Relaxation training and yoga, as well as mindfulness, to determine what stressors increase physical symptoms could be useful for both sexes. Insight therapy is useful with 15 codetype men who are usually psychologically astute, though 15 codetype women are more practical and will be more responsive to practical solutions.

THERAPEUTIC FEEDBACK LANGUAGE

For men: Your profile suggests you are a sensitive and perceptive person who enjoys artistic, creative activities and interests. You are generally a non-aggressive person and others may feel you too readily “turn the other cheek” in response to others’ anger and unreasonable demands. It may be hard for you to assert yourself, even when it would be reasonable to do so. You may experience a number of physical symptoms that cause you distress and that have been hard to diagnose. They may increase in intensity when you are stressed or angry. Assertiveness training and CBT can be helpful in decreasing some of your symptoms.

For women: Your profile suggests you are a practical, sensible, self-reliant, action-oriented woman. You can enjoy the company of men and their more traditional male activities. You also are experiencing a number of physical symptoms that may be troubling you and interfering with your activities. Perhaps you or somebody you were close to experienced frightening physical problems when you were a child or perhaps you have been through some frightening physical trauma that has caused you to become concerned about your physical health. Relaxation exercises and yoga can be useful ways to deal with stress, especially since you may be an active woman.

156 Code

Male

Low 0 Home dependency. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, lack of skills with the opposite sex, being nonresponsive or nonverbal, tension.

Low 2/3 Home dependency.

Low 4 Home dependency, home conflict.

Low 7/8/9 Home dependency.

Nothing Low Home dependency, home conflict, insomnia.

Female

Low 0 Socially extroverted, resistant in the interview.

Low 2 Socially extroverted.

Low 4 Shy in the interview.

Nothing Low Distractible in study, restless, 8+ conferences.

- Note: Scale 5 coded high was infrequently associated with 8+ conferences.

(Drake & Oetting, 1959)

157 Code

Male

Low 0 Home conflict, home dependency, one interview only, wants reassurance only, lacks knowledge or information. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, lack of skills with the opposite sex, being nonresponsive or nonverbal, tension.

Low 2/3/4/6/8/9 Home conflict, home dependency, wants reassurance only.

Nothing Low Lacks skills with the opposite sex, home conflict, mother conflict, sibling conflict, home dependency, wants reassurance only, nonresponsive or nonverbal, tense, indecisive, unhappy, worries a great deal, insomnia, confused. Note: Scale 5 coded high was infrequently associated with tension.

Female

Low 0 Socially extroverted.

Low 3 Cried in the interview.

Nothing Low Distractible in study, sibling conflict, headaches.

- Note: Scale 5 coded high was infrequently associated with headaches.

(Drake & Oetting, 1959)

158 Code

Male

Low 0 Home conflict, home dependency, lacks knowledge or information, aggressive or belligerent. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, lack of skills with the opposite sex, being nonresponsive or nonverbal, tension.

Low 2/ 3/4/6/7 Home conflict, home dependency.

Low 9 Introverted or self-conscious or socially insecure, home conflict, home dependency.

Nothing Low Home conflict, home dependency, indecisive, imhappy, worries a great deal, insomnia, confused.

Female

Low 0 Socially extroverted, verbal.

Nothing Low Distractible in study, father conflict, mother conflict, sibling conflict, 8+ conferences, lacks skills with the opposite sex.

- Note: Scale 5 coded high was infrequently associated with father conflict, 8+ conferences.

(Drake & Oetting, 1959)

159 Code

Male

Low 0 Mother conflict, home dependency, poor rapport.

- Note: Scale 0 coded low was infrequently associated with poor rapport. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, shyness in the interview, lack of skills

with the opposite sex, being nonresponsive or nonverbal, being nonverbal or a nonrelator, tension, indecisiveness.

Low 2/3 Mother conflict, home dependency, poor rapport.

Low 4 Home conflict, mother conflict, home dependency, poor rapport.

Low 6 Mother conflict, home dependency, poor rapport, rationalizes a great deal.

Low 7/8 Mother conflict, home dependency, poor rapport.

Nothing Low Home conflict, mother conflict, home dependency, insomnia, poor rapport.

Female

Low 0 Socially extroverted, vague goals, marriage oriented, verbal.

Low 2/3 Socially extroverted, vague goals.

Low 4 Socially extroverted, shy in the interview, vague goals, nonresponsive.

Low 6/7/8 Socially extroverted, vague goals.

Nothing Low Socially extroverted, vague goals, distractible in study.

(Drake & Oetting, 1959)

16/61 Codes

The addition of Scale 6 to Scale 1 adds hypersensitivity, vigilance for criticism, and a tendency to rationalize and project blame onto others to the Scale 1 somatic complaints and anxieties. These people experience physical discomfort, but are also feeling vulnerable to being blamed and criticized. Consequently, they are described as defensive, rigid, grouchy, stubborn, and sensitive to demands being made of them. They are evasive, easily wounded, take things personally, and are quick to anger. At times their sensitivity may shade towards paranoia and the misunderstanding of others' motives. Typically, they are unaware of how their irritability and hostility create a negative, defensive response from others.

Conceptually, the codetype reflects an individual who feels sick, physically infirm, unfairly treated, and angry with the world. These individuals are defensive, as if anticipating being criticized or judged because of their symptoms, and are quick to feel misunderstood.

If Scale 8 is elevated, unusual somatic preoccupations and, in some cases, somatic delusions may reflect an underlying psychotic breakdown. Bodily preoccupations may serve as a defense against overt psychosis. Psychotic behaviors are rare in a 16/61 code pattern, which itself is a rare code. The most common third highest scales for men tend to be Scales 2 and 4 and for women, Scales 3 and 8.

- Feelings of somatic vulnerability; wide range of somatic complaints, especially tension, fatigue, disturbed sleep, and headache, with fears that such complaints won't be taken seriously; projection, suspiciousness, resentment, and persecutory ideation. Significant anxiety; some fearfulness. Socially alienated. Sensitive and over-reactive to criticism; resentful of demands; quick to feel dominated and to resist. Querulous and peevish. Chronic conflicts with others; irritable, angry, blaming; feels mistreated; stubborn and rigid. Look for somatic symptoms on a delusional basis; other signs of psychosis.
- Adolescents in treatment with this 1-6/6-1 pattern (Marks et al., 1974) were referred for emotional overcontrol. Family disruption was frequent for these adolescents. They were defensive and evasive, egocentric, self-centered, and self-indulgent. They did not report physical complaints however. The Marks, Seeman, and Haller book should be consulted for further information concerning this pattern.

Description:

Somatic and hypochondriacal preoccupation, projected hostility, might be a defence against emerging psychosis

Possible Diagnoses:

Somatization, Paranoid schizophrenia

Female

Low 0 Socially extroverted, resistant in the interview.

Low 2 Socially extroverted.

Low 4 Shy in the interview.

Low 5 Socially extroverted, headaches.

Nothing Low Restless, 8+ conferences.

o **Check:** *HEA, RC1, HEA1, HEA2, HEA3, ANX, DEP, DEP1, DEP2, BIZ, BIZ1, CYN2, TPA2, WRK, PSYC, RC6, Dr3, Dr4, Hy3, Hy4, Pd4, Pa1, Pf1, Pf2, Pf3, Pf4, Pa3 (low), Sc1, Sc3, Sc6, Ma4.*

TREATMENT

Anticipating criticism and judgment, these individuals are defensive, resentful, and bitter. This often elicits anger and resentment from others, thereby confirming their need for preemptive self-protection. Look for childhood experiences of being criticized, judged, or physically abused. These individuals are sensitive to criticism or demands, which suggests past conditioning experiences of having been criticized, dominated, and judged.

Psychotherapy needs to be supportive initially, as a therapeutic relationship is hampered by the patient's vigilance. Criticisms of other therapists should be understood by the current therapist as a sign that the patient is feeling misunderstood and unsupported by the therapist. Cognitive behavioral and dialectical behavior (DBT) therapies can help the patient to express anger directly, rather than allowing rationalized resentments to accumulate. A diary of when physical symptoms increase in intensity can be useful to see if it is linked to the buildup of anger and/or resentments. Catharsis around past criticisms and emotional wounds can also be helpful once trust is established.

o **Treatment:** Quick to experience therapy as critical, demanding, and controlling; and to place therapist in no-win positions. Irritable. Fears not being taken seriously. Resentful of exploration; suspicious of support.

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you are experiencing a number of physical symptoms and concerns that may be interfering with your quality of life. At the same time, you may be feeling vulnerable to being criticized and judged right now, perhaps related to your physical worries. You are a sensitive person and people's insensitivity is especially painful to you, but currently you are feeling even more vulnerable, as if you need to protect yourself. No wonder people may see you as cautious, distrustful, and ready to protect yourself, since it's hard to know whom you can trust. Perhaps recently somebody has accused you of something unfairly, or perhaps you grew up with a controlling or abusive parent, so you learned to be vigilant for criticism and unfair punishments. Your physical symptoms may become worse when you feel angry and are unable to express it safely. Discuss with your therapist any experiences of unfair criticisms or attacks to your self-esteem. Work on asking for what you want so you don't allow resentments to accumulate.

167 Code

Male

Low 0 One interview only, lacks knowledge or information.

Nothing Low Lacks skills with the opposite sex, mother conflict, sibling conflict, nonresponsive or nonverbal, tense, indecisive, unhappy, worries a great deal, insomnia, confused.

Female

Low 0 Socially extroverted, resistant in the interview.

Low 2 Socially extroverted.

Low 3 Cried in the interview.

Low 4 Shy in the interview.

Low 5 Anxieties, nervous, exhaustion, insomnia, headaches, indecisive, physical inferiority, lacks self-confidence, socially insecure.

Nothing Low Restless, headaches, 8+ conferences, sibling conflict.

(Drake & Oetting, 1959)

168 Code

Male

Low 0 Lacks knowledge or information, aggressive or belligerent.

Low 9 Introverted or self-conscious or socially insecure.

Nothing Low Indecisive, unhappy, worries a great deal, insomnia, confused

Female

Low 0 Socially extroverted, verbal, resistant in the interview, 8+ conferences.

Low 2 Socially extroverted, 8+ conferences.

Low 3 8+ conferences.

Low 4 Shy in the interview, 8+ conferences.

Low 5 8+ conferences, anxieties, headaches, physical inferiority, distractible in study.

Low 7/9 8+ conferences.

Nothing Low 8+ conferences, depressed, restless, father conflict, mother conflict, sibling conflict, lacks skills with the opposite sex.

(Drake & Oetting, 1959)

169 Code

Male

Low 0 Aggressive or belligerent. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, shyness in the interview, being nonresponsive or nonverbal, being nonverbal or a nonrelator, indecisiveness

Female

Low 0 Socially extroverted, marriage oriented, resistant in the interview, verbal.

Low 2 Socially extroverted.

Low 3 Vague goals.

Low 4 Shy in the interview, nonresponsive.

- Note: Scale 9 coded high was infrequently associated with shyness in the interview.

Low 5 Socially extroverted, exhaustion, headaches, verbal.

Nothing Low 8+ conferences, restless.

(Drake & Oetting, 1959)

17/71 Codes

Chronically tense and anxious as well as guilty and ruminative, these individuals manifest many tension-related complaints and physical symptoms. Obsessive concern with body functions and disorders, along with extreme intellectualization, is common. Underlying feelings of guilt, inferiority, pessimism, and difficulties in being assertive are typical symptoms. In addition to feeling insecure, inhibited, inferior, and guilty, they manifest obsessive thoughts, fears, and panic that they are “losing their health.” Usually Scale 2 is also elevated since chronic anxiety can lead to depression. Typically, these individuals are passive and non-confrontational. They tend to worry about their

lack of interpersonal skills and they easily feel guilty if they are demanding in any way. This codetype is more commonly obtained by men than women. For both genders, the most common three point codes are 172/712 and 173/713.

- Wide range of somatic complaints, especially chronic tension, cardiovascular complaints, and problems with thinking, memory, and concentration. High general distress. Apprehensive, anxious, and obsessed about physical illness and mental and physical breakdown; fears sudden onset of severe illness; fears loss of mental function and control. Some guilt and dysphoria usually present. Disturbed sleep. Feels inadequate and inferior; feels unable to perform duties and responsibilities and seeks to avoid these. Prefers that others take responsibility. May be passive-aggressive and avoidant. Socially awkward, self-conscious, and unassertive, but also irritable. Look for association between accident or injury and onset of symptoms.
- With this pattern, chronic, mild anxiety often exists (Hovey & Lewis, 1967).

Male

Low 0 One interview only, lacks knowledge or information.

Nothing Low Lacks skills with the opposite sex, mother conflict, sibling conflict, nonresponsive or nonverbal, tense, indecisive, unhappy, worries a great deal, insomnia, confused.

Female

Low 3 Cried in the interview.

Low 5 Anxieties, nervous, exhaustion, insomnia, headaches, lacks self-confidence, indecisive, socially insecure.

Nothing Low Headaches, sibling conflict.

(Drake & Oetting, 1959)

Description:

High somatic tension, obsessive patterns focusing on somatic complaints and pain, inferiority feelings, may report sleep problems, depression

Possible Diagnoses:

Somatization, Obsessive-compulsive disorder, Eating disorder

o **Check:** *HEA, RC1, HEA1, HEA2, HEA3, RC7, ANX, OBS, DEP, DEP1, DEP2, BIZ, BIZ1, ANG2, TPA1, SOD2, WRK, NEGE, Dr1, Dr3, Dr4, Hy3, Hy4, Pd5, Sc3, Sc4, Sc6, Si1, Do* (low).

TREATMENT

This essentially is a neurotic disorder. Consequently, these self-critical and anxious individuals profit from reassurance, supportive psychotherapy, thought-stopping techniques, assertiveness training, and relaxation training. They tend to be responsible, conscientious individuals who follow recommendations. Implosive-type therapies, Gestalt therapies, and insight therapy can also be useful. Look for childhood conditioning experiences of illnesses in them or in someone close to them. The profile reflects a constant apprehensiveness about the onset of some unpredictable catastrophic illness.

Treatment: May be resistant to insight and psychological approaches; benefit from behavioral approaches. Intellectualized. Treatment plans initially focused on relief of anxiety and such problems as disturbed sleep are more effective than those targeting somatization. Later, may benefit from plans emphasizing “work hardening.”

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you are experiencing a constant state of anxiety and worry about physical symptoms and the possibility that you have a serious disease or disorder. You may spend a great deal of time researching various symptoms and seeking medical advice so you likely experience little joy or relaxation. You are a responsible, prone to worry, dutiful person and you easily feel guilty if you feel you have been too demanding or irritated with others. Conflict is especially upsetting to you. Perhaps you have recently experienced a physical disorder that frightened you and caused you to feel in a state of constant alertness in case your symptoms worsen. Or perhaps you or somebody you depended on in childhood experienced physical trauma that was frightening to you. No wonder you responded by becoming very aware of any physical symptoms that might be associated with illness and physical decline. Your therapist may consider medicine to help you control your worst panic attacks. Learning to stop your negative thoughts while practicing deep breathing and other relaxation techniques can be helpful. Explore any childhood events that could have predisposed you to be on constant alert for danger. Notice when your thoughts are interrupted by unwanted worries about your health and explore whether you might be distracting yourself from other legitimate concerns. Learn relaxation techniques and practice assertiveness training as well as learning to distinguish between appropriate guilt and unrealistic self-criticism.

178 Code

Male

Low 0 Introverted or self-conscious or socially insecure, one interview only, nonresponsive or nonverbal, tense, indecisive, lacks knowledge or information, vague goals, confused, aggressive or belligerent.

- Note: Scale 0 coded low was infrequently associated with introversion or self-consciousness or social insecurity, being nonresponsive or nonverbal, indecisiveness.

Low 2/3/4/5/6/9 Introverted or self-conscious or socially insecure, nonresponsive or nonverbal, tense, indecisive, lacks knowledge or information, vague goals, confused.

Nothing Low Introverted or self-conscious or socially insecure, lacks skills with the opposite sex, mother conflict, sibling conflict, nonresponsive or nonverbal, tense, indecisive, unhappy, worries a great deal, insomnia, lacks knowledge or information, vague goals, confused.

Female

Low 0 Nervous, insomnia, lacks self-confidence, verbal.

Low 2 Nervous, insomnia, lacks self-confidence.

- Note: Scale 2 coded low was infrequently associated with lack of self-confidence.

Low 3 Nervous, insomnia, lacks self-confidence, cried in the interview.

Low 5 Nervous, insomnia, headaches, anxieties, exhaustion, lacks self-confidence, indecisive, distractible in study, socially insecure.

Low 6/9 Nervous, insomnia, lacks self-confidence.

Nothing Low Nervous, insomnia, headaches, exhaustion, depressed, lacks self-confidence, 8+ conferences, father conflict, mother conflict, sibling conflict, lacks skills with the opposite sex.

(Drake & Oetting, 1959)

179 Code

Male

Low 0 Home conflict, one interview only, lacks knowledge or information, aggressive or belligerent, defensive. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, shyness in the interview, being nonresponsive or nonverbal, being nonverbal or a nonrelator, indecisiveness.

Low 2/3/4/5 Home conflict, defensive.

Low 6 Home conflict, defensive, rationalizes a great deal.

Low 8 Home conflict, defensive.

Nothing Low Lacks skills with the opposite sex, home conflict, mother conflict, sibling conflict, nonresponsive or nonverbal, tense, indecisive, unhappy, worries a great deal, insomnia, confused, defensive.

- Note: Scale 9 coded high was infrequently associated with indecisiveness, being nonresponsive or nonverbal, worrying a great deal, lack of skills with the opposite sex

Female

Low 0 Confused, nervous, exhaustion, distractible in study, marriage oriented, sibling conflict, verbal, socially extroverted.

- Note: Scale coded low was infrequently associated with confusion, exhaustion, sibling conflict.

Low 2 Confused, nervous, distractible in study, sibling conflict, extroverted.

- Note: Scale 2 coded low was infrequently associated with confusion.

Low 3 Confused, nervous, distractible in study, vague goals, sibling conflict, cried in the interview.

Low 4 Confused, nervous, distractible in study, sibling conflict, shy in the interview, nonresponsive.

- Note: Scale 9 coded high was infrequently associated with shyness in the interview.

Low 5 Confused, indecisive, lacks self-confidence, distractible in study, nervous, anxieties, insomnia, headaches, exhaustion, sibling conflict, verbal, socially insecure.

Low 6/8 Confused, nervous, distractible in study, sibling conflict.

Nothing Low Confused, nervous, headaches, distractible in study, sibling conflict.

(Drake & Oetting, 1959)

18/81 Codes

Individuals with this pattern are likely to present with somatic complaints, some of which may be odd, unlikely, and even bizarre. In some cases, they are somatic delusions; in other cases, the somatic complaints may represent a defense, a distracting focus, against the emergence of psychosis. Easily distracted and confused, difficulties with concentration, thinking, and memory are typical. These individuals may show flat affect, with generalized unhappiness and complaints of depression. Poor social and sexual adjustment is typical. They lack trust and feel alienated from others, so they keep others at a distance. They feel isolated, particularly if Scale 0 is also elevated. Some show a nomadic lifestyle with a poor work history. When stressed, these persons can become disoriented, distractible, and confused. Emotionally constricted, some may exhibit episodes of sudden belligerence if they feel cornered or threatened. Their interpersonal life is often compromised by their difficulty with intimacy and their odd somatic preoccupations. They have difficulty recognizing, labeling, and expressing complex, nuanced emotions, so

their emotional life tends to be expressed symbolically through their somatic symptoms and preoccupations. The most common three-point codetypes are 182/812, 183/813, and 187/817.

- Emphasis on cognitive and unusual sensory and musculoskeletal symptoms, and lethargy, but with many others as well. Multiple mental symptoms, including distractibility, forgetfulness, impaired judgment, dissociation, derealization, intrusive thoughts, and cognitive disruption/disorganization. Peculiar ideas about health problems or bodily functions, if not somatic delusions, should be ruled out, as should hallucinations and ideas of reference. Spends much time in fantasy and daydreaming. Immaturity, fearfulness, anxiety, depression, and anhedonia are probable. Depression may be more evident in lethargy and apathy, vegetative signs and symptoms, including sleep disturbance, and in depressive cognition and attitudes (pessimism, helplessness, hopelessness, worthlessness) than in depressed mood. Sexual problems. Anger, hostility, irritability, and inchoate rage often significant. Severe social alienation, with suspicion and mistrust; seen by others as eccentric and peculiar. Passive-aggressive and schizotypal trends are common. Look for history of under- and unstable employment, nomadic lifestyle, rootlessness, suicidal ideation, thought disorder, and paranoid ideation.
- Harbors feelings of hostility and aggression but can't express them in modulated, adaptive manner; either inhibited and "bottled---up" or overly belligerent and abrasive; feels socially inadequate; lacks trust in other people; isolated, alienated; nomadic---life style; unhappy and depressed; flat affect; may be confused and distractible; can be diagnosed as schizophrenic.

When there is an elevated F scale associated with this profile, one possible diagnosis is schizophrenia.

Individuals with this high point pair are described as having difficulty handling stress and may show clearly delusional thinking regarding bodily functions and bodily illnesses. They harbor feelings of anger and hostility, but are unable to express these overtly for fear of retaliation from others. They either inhibit expression—almost completely resulting in the feeling of being “bottled up”—or they are overly belligerent, abrasive, and caustic in speech. Internalization of feelings may be represented via numerous somatic complaints and heightened physiological reactivity. Trust appears to be a crucial issue, resulting in limited social contacts and subsequent feelings of loneliness, alienation, isolation, and rejection. Clients with this high point pair have fundamental and disturbing questions concerning their own sexual identity and worth, and feel generally misunderstood and not a part

of the general social environment. The possibility of some type of prepsychotic disorder also should be considered.

Symptoms and Behaviors

Peaks on Scales 1 and 8 are found with persons who present a variety of vague and unusual complaints (check the HEA/Health Concerns scale). They may also experience confusion, disorientation, and difficulty in concentrating. They focus on physical symptoms as a way to organize their thoughts, although the beliefs related to these symptoms may represent delusions. Their ability to deal effectively with stress and anxiety is extremely limited. They will experience interpersonal relationships with a considerable degree of distance and alienation. Often, they will feel hostile and aggressive but will keep these feelings inside. However, when such feelings are expressed, the expressions will be made in an extremely inappropriate, abrasive, and belligerent manner. Others will perceive these individuals as eccentric or even bizarre. They will distrust others and may disrupt their relationships because of the difficulty in controlling their hostility. There may even be paranoid ideation, which will probably, but not necessarily, be reflected in an elevated Scale 6. They might be confused, distractible, and disoriented.

Common scales that are elevated along with 1 and 8 are 2, 3, and/or 7. These serve to color or give additional meaning to 18/81. Thus, an elevated Scale 2 will emphasize self-critical, pessimistic dimensions; 7, the presence of fears and anxiety (check the ANX/ Anxiety, A/Anxiety, FRS/Fears, and OBS/Obsessions scales); and 3, the likelihood of conversions and/or somatic delusions. The 18/81 code is frequently diagnosed as schizophrenia, especially if the *F* scale is also high. With a normal *F*, hypochondriasis is an important possibility, but if Scale 7 is elevated, an anxiety disorder is also strongly suggested.

Personality and Interpersonal Characteristics

Personality difficulties of a long-standing nature are likely to be a significant factor. The 18/81 clients are low in interpersonal trust and feel socially inadequate. They will feel socially isolated and alienated. Consistent with this, their histories will often reveal a nomadic lifestyle with poor work histories (check the WRK/Work Interference scale).

- These people tend to be remote from people and to feel inadequate socially (Hovey & Lewis, 1967),
- People with this combination tend to have feelings of hostility and aggression which they either inhibit altogether or show in a belligerent way. Psychiatric patients may complain about somatic symptoms that are so bad as to seem delusional (Graham, 1977).
- Adolescents in treatment with the 14/11-1 pattern (Marks et al., 1974) presented themselves as physically ill. As children they had been seriously ill and currently only one-half of them were in good health. They

were seen as insecure, unambitious, and constantly demanding attention. The Marks, Seeman, and Haller book should be consulted for further information concerning this pattern.

Persons with the 18/81 code type harbor feelings of hostility and aggression, and they are not able to express these feelings in a modulated, adaptive manner. Either they inhibit expression almost completely, which results in feelings of being "bottled up," or they are overly belligerent and abrasive. 18/81 persons feel socially inadequate, especially around members of the opposite sex. They lack trust in other people, keep them at a distance, and feel generally isolated and alienated. A nomadic lifestyle and a poor work history are common. Psychiatric patients with the 18/81 code type most often are diagnosed as schizophrenic, although diagnoses of anxiety disorders and schizoid personality disorder are sometimes given. 18/81 persons tend to be unhappy and depressed, and they may display flat affect. They present somatic concerns (including headaches and insomnia), which at times are so intense that they border on being delusional. 18/81 persons also may be confused in their thinking, and they are very distractible.

Description:

Vague and odd medical complaints, cannot acknowledge aggression, often passive-aggressive, socially inadequate, lack trust in others, alienated, schizoid

Possible Diagnoses:

Pedophilia, Schizoid Pers. dis., Acute schizophrenia, Affective dis., Borderline Pers. Dis.

Male

Low 0 Lacks knowledge or information, aggressive or belligerent.

Low 9 Introverted or self-conscious or socially insecure.

Nothing Low Indecisive, unhappy, worries a great deal, insomnia, confused.

Female

Low 0 Verbal.

Low 5 Anxieties, headaches, distractible in study.

Nothing Low Depressed, father conflict, mother conflict, sibling conflict, 8+ conferences, lacks skills with the opposite sex.

(Drake & Oetting, 1959)

o **Check:** *HEA, RC1, HEA1, HEA2, HEA3, ANX, FRS1, DEP, DEPI, DEP4, BIZ, BIZ1, BIZ2, DisOrg, CYN1, CYN2, LSE1, WRK, PSYC, Dr1, Dr3, Dr4, Hy3, Hy4, Pd4, Pa1, Sc1, Sc2, Sc3, Sc4, Sc5, Sc6.*

TREATMENT

These clients tend to show little response to reassurance and typically do not do well with insight therapy. Look for childhood conditioning experiences of being subjected to hostility from people on whom they depended. Some of these patients were slow to mature and experienced childhood illnesses along with parental neglect that led them to feel vulnerable and unsafe. Severe teasing, put downs, or other kinds of identity damaging experiences combined with feelings of vulnerability due to physical frailty are common with this kind of profile. Supportive, reparenting, and life skills training therapies are recommended since psychological insights tend to be interpreted by them as an attack on their self-image. Antipsychotic medication may be necessary during particularly stressful events, especially if somatic delusions are severe.

o **Treatment:** Rule out schizophrenia-spectrum disorder. Resistant to insight, reassurance, and psychological approaches. Treatment plans initially focused on relief of psychotic symptoms, depression, anxiety, and problems such as disturbed sleep are more effective than those targeting somatization. Course tends to be chronic.

- Frequent diagnoses: schizophrenia (especially with elevated F) hypochondriasis (with lower F), anxiety disorder (with elevated 7).
(Groth-Marnat, 2009)

Treatment Implications

Engaging them in therapy will be difficult because their level of insight will be poor. In addition, they will be distrustful, pessimistic, alienated, and hostile (check the TRT/Negative Treatment Indicators scale).

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests you are experiencing a great deal of concern about your physical symptoms. You probably imagine many possible terrible things that could be wrong with you and these thoughts and preoccupations likely cause you great distress. Sometimes people with your profile grew up in environments where they felt vulnerable and unprotected. You may have been small for your age or perhaps experienced a number of frightening illnesses as a child that made you very sensitive to any physical sensations that could signal something is wrong with you. You

may currently be feeling unsafe and vulnerable and concerned about obtaining the right diagnosis, perhaps feeling that nobody is on your side and ready to help. Make sure you get even a small amount of exercise because it will help relieve stress. When your imagination runs wild about all the things that could be wrong with you, learn to switch your mind to other things in your life. Focus on getting some small pleasure or a chore accomplished. Take a mindfulness class so you can learn to identify your feelings and express them well to others.

189 Code

Male

Low 0 Lacks knowledge or information, lacks academic motivation, aggressive or belligerent. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, shyness in the interview, being nonresponsive or nonverbal, being nonverbal or a nonrelator, indecisiveness.

Low 6 Rationalizes a great deal.

Nothing Low Indecisive, vmhappy, worries a great deal, insomnia, confused.

- Note: Scale 9 coded high was infrequently associated with indecisiveness and worrying a great deal.

Female

Low 0 Confused, restless, verbal, 8+ conferences, resistant in the interview, marriage oriented, socially extroverted.

- Note: Scale 0 coded low was infrequently associated with confusion.

Low 2 Confused, restless, exhaustion, verbal, 8+ conferences, resistant in the interview, socially extroverted.

- Note: Scale 2 coded low was infrequently associated with confusion.

Low 3 Confused, restless, verbal, 8+ conferences, resistant in the interview, vague goals.

Low 4 Confused, restless, verbal, 8+ conferences, resistant in the interview, nonresponsive, shy in the interview.

Low 5 Confused, restless, anxieties, exhaustion, headaches, verbal, 8+ conferences, resistant in the interview, wants answers, distractible in study.

- Note: Scale 5 coded low was infrequently associated with resistance in the interview.

Low 6 Confused, restless, verbal, 8+ conferences, resistant in the interview.

Low 7 Confused, restless, verbal, 8+ conferences, resistant in the interview.

Nothing Low Confused, restless, depressed, verbal, 8+ conferences, resistant in the interview, father conflict, mother conflict, sibling conflict, lacks skills with the opposite sex.

19/91 Codes

(see also 129/219 and 139 Codes if Scales 2 & 3 are Within Five T-Score Points of Scale 9)

This profile occurs rarely. Multiple somatic complaints, a high energy level, agitation, grandiosity, argumentativeness, and attention-seeking characterize this profile. Individuals with this codetype are preoccupied with bodily malfunctions and possible disabilities and at the same time they express a cavalier attitude about those disabilities.

This pattern may reflect central nervous system or endocrine dysfunction expressed in the form of a high energy level and agitation combined with numerous physical complaints. If a genetic predisposition or physical etiology has been ruled out, it's possible that the hypomania is reflecting an underlying depression (particularly if Scale 2 is below *T*-45) and that the manic defense may be indicating an attempt to deal with either dependency needs that the person finds frightening or an anticipated loss. Such persons appear extroverted, surgent, assertive, and sometimes aggressive, although they are quite dependent and need a great deal of attention and approval. Although ambitious, they often lack definite goals, or jump from goal to goal and are distractible. Most commonly, Scale 3 or 4 is the third highest elevation.

- Multiple somatic complaints with emotional volatility, tension, irritability, restlessness, agitation, and drivenness. May focus on physical symptoms to distract from interpersonal problems. Extroverted and outgoing but conflicted over dependency versus independence, with stubbornness and demandingness. Self-confident but unrealistic. May be grandiose. Quick to feel dominated or "bossed." Others may see them as compensating and as difficult in relationships, but with little or no insight into this behavior. Physical symptoms may be partially embraced as an excuse for underachievement. Look for narcissistic or antisocial trends; mood disorder (e.g., mania) or reaction to physical narcissistic injury, especially one that has created a permanent change in health status, mobility, function, or appearance, and has frustrated ambition; and for possible suicidal ideation as a reaction to such injury.

- Extreme distress and turmoil; anxious, tense, restless; somatic complaints; reluctant to accept psychological explanations; superficially extraverted, aggressive, and belligerent but actually passive---dependent person who is trying to deny it; ambitious; high drive level but lacks clear goals; frustrated by inability to achieve at high level; sometimes found in brain---damaged persons who are experiencing difficulty in coping with deficits.

Clients with this high point pair are described as being rather tense, anxious, and experiencing a great deal of emotional turmoil. They expect a high level of achievement from themselves but lack clear and definitive goals. Much of their frustration occurs due to their inability to obtain their rather high levels of aspiration. The elevation on

Scale 1 may be considered an indicator of basic passivity and strong needs for dependency which are being struggled against in counter-phobic denial fashion by hyperactivity and tremendous efforts to produce. Such individuals are basically passive-dependent and are trying to compensate for their perceived inadequacies. This high point pair also may be found among individuals with brain damage who are experiencing difficulty coping with their limitations and deficits. However, the diagnosis of cerebral dysfunction never should be made based solely on MMPI-2 high point pairs.

Symptoms and Behaviors

The 19/91 code is rarely encountered but is important because it may suggest organic difficulties relating to endocrine dysfunction or the central nervous system. Complaints are likely to include gastrointestinal difficulties, exhaustion, and headaches. There will be extensive complaining and overconcern with physical difficulties, but these patients may paradoxically attempt to deny and conceal their complaints at the same time. In other words, they may invest significant energy in avoiding confrontations relating to their complaints, yet will make a display of these techniques of avoidance. They will typically be extraverted, talkative, and outgoing, but also tense and restless. They might be in a state of turmoil and experience anxiety and distress. The expectations they have of themselves will be extremely high, yet their goals will be poorly defined and often unobtainable. If their complaints have no organic basis, their behavior may be an attempt to stave off an impending depression. Often, this depression will be related to strong but unacceptable dependency needs.

Both hypochondriasis and manic states are frequent diagnoses and may occur simultaneously. These may be in response to, and exacerbated by, an underlying organic condition, an impending depression, or both. Corresponding elevations on Scales 4 and 6 make the possibility of a passive-aggressive personality an important diagnostic consideration.

Personality and Interpersonal Characteristics

Superficially, these clients might appear outgoing, assertive, and ambitious. However, they are likely to have an underlying passive dependent core to their personalities.

Persons with the 19/91 code type are likely to be experiencing a great deal of distress and turmoil. They tend to be very anxious, tense, and restless. Somatic complaints, including gastrointestinal problems, headaches, and exhaustion, are common, and these people are reluctant to accept psychological explanations of their symptoms. Although on the surface 19/91 individuals appear to be verbal, socially extroverted, aggressive, and belligerent, they are basically passive-dependent persons who are trying to deny this aspect of their personalities.

19/91 persons have a great deal of ambition. They expect a high level of achievement from themselves, but they lack clear and definite goals. They are frustrated by their inability to achieve at a high level. The 19/91 code type is sometimes found for brain-damaged individuals who are experiencing difficulties in coping with their limitations and deficits.

1-9 See also the 9-1 combination, p. 224.

- This person is usually quite tense and may be distressed by an inability to attain high goals (Lachar, 1974).
- He/she tends to be very anxious, tense, and restless. On the surface the person appears to be extroverted, verbal, and aggressive, but underneath he/she is usually a passive, dependent person. These people tend to be ambitious but lack definite goals (Graham, 1977).
- This person tends to be one who has coronary attacks (Caldwell, 1972),

Description:

Agitation, irritability, distress, high ambitions, passive-dependent, lack coherent goals, yet present carefree and competent exterior

Possible Diagnoses:

Masked depression, PTSD, brain damage, Dependent pers. dis., Sexual masochism

Male

Low 0 Aggressive or belligerent. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, shyness in the interview, being nonresponsive or nonverbal, being nonverbal or a nonrelator, indecisiveness.

Low 6 Rationalizes a great deal.

Female

Low 0 Marriage oriented, socially extroverted, verbal.

Low 2 Socially extroverted.

Low 3 Vague goals.

Low 4 Shy in the interview, nonresponsive.

- Note: Scale 9 coded high was infrequently associated with shyness in the interview.

Low 5 Exhaustion, headaches, verbal.

(Drake & Oetting, 1959)

o **Check:** *HEA, RCI, HEA1, HEA2, HEA3, DEP4, Hp, ANG1, LSE1* (low), *LSE2* (low), *SOD1* (low), *SOD2* (low), *AGGR, D3, Hy3, Hy4, Pa1, Sc1, Sc5, Sc6, Ma2, Ma4, Si1* (low), *Si2* (low).

TREATMENT

Conceptually, this profile can be understood as reflecting a constant need to be productive and to protect against future frustration, perhaps out of fear of experiencing a loss and subsequent depression. The physical complaints and anxieties could be a result of extreme tension. These symptoms become a source of secondary anxiety as the hypomanic individual becomes concerned about physical impediments to maintaining control over their reward system. If mania is evident, medication is recommended. Relaxation training, managing distractibility as well as realistic goal-setting and teaching awareness of physical responses to stress can be helpful. Self-esteem building can also help the patient lower their unrealistic goals.

Treatment: Rule out mood disorder. May be resistant to insight and psychological approaches. Benefits from support. Treatment plans initially focused on current difficulties and interpersonal struggles, and on major apprehensions about the future of work, relationships, and so forth are more effective than those targeting somatization. Consider neuropsychological evaluation.

- Frequent diagnoses: hypochondriasis, manic states (may occur simultaneously). May be in response to, and exacerbated by, an underlying organic condition, an impending depression, or

both; passive-aggressive personality (especially if 4 and 6 are elevated).
(Groth-Marnat, 2009)

Treatment Implications

Psychotherapy will be difficult because these individuals are reluctant to accept a psychological explanation for their complaints (check the TRT/Negative Treatment Indicators scale).

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests you are an energetic, driven, ambitious person. You likely have two speeds at which you operate: off and “full on.” You also appear to be experiencing a lot of physical symptoms and worries. Perhaps you have recently experienced an illness or disability and, although you want to push through the pain and discomfort, it causes you a great deal of concern. You enjoy being a “take charge” and in control person, so physical disability will be especially upsetting to you. You like to argue your point of view and enjoy attention, so you are not afraid to speak your mind. Currently, however, you may be feeling more vulnerable because of your physical concerns. Perhaps you grew up in a family where you felt a strong need to prove yourself and achieve a great deal in order to obtain your and others’ approval. Perhaps that drive is adding to your physical symptoms, because you put so much stress on yourself. Work with your therapist to define what you really want versus what you think you should achieve in order to obtain others’ approval. Learn to recognize physical symptoms of stress and learn relaxation techniques to relieve it. Learn to stick at a task and not become easily distracted.

10/01 Codes

This rare code is associated with persons who are socially uncomfortable, withdrawn, and suffer vague and anxiety-provoking physical symptoms. Research has suggested that introversion and extraversion are stable personality characteristics, rather than symptoms of pathology, although extreme levels of either may reflect learned behavior. Others may judge the 10/01 as aloof, passive, quiet, and unassertive. They report physical complaints and concerns but not psychological discomfort or emotional distress. These conventional, rule-abiding individuals tend to accept physical discomfort, perhaps accepting it as their lot in life. When Scale 8 is also elevated as the third highest scale, schizoid withdrawal and social inadequacies are suggested, usually combined with odd somatic complaints. Most often, Scale 2 is the third highest scale, and when elevated above $T-65$, the person is likely to show depression, accompanied by the lack of a social support system. Look for childhood experiences of deficient socialization and a lack of parental warmth combined with frightening experiences of illness and physical infirmity.

o Look for somatic preoccupation and social isolation. Socially passive; timid. Conventional and resigned. Check third highest scale.

Description:

Social discomfort, passive-avoidant, conventional, somatic complaints

TREATMENT

Assertiveness training, social skill building, and teaching the recognition, labeling, and appropriate expression of anger can be helpful in dealing with their tendency toward passivity and withdrawal. If they are in a significant relationship, help them understand that others need more expressions of physical affection and social interaction. Explore any childhood memories of being ill or frightened of physical symptoms, with no one to turn to. Help them understand how physical symptoms can be linked to stress.

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests you are comfortable in your own company and can happily spend long periods alone. When socializing, you prefer to be with small groups of close friends. Being in large groups of people you don't know or becoming the center of attention unpredictably causes you stress. There is nothing wrong with being an introvert. At the same time, you may have grown up in a family where emotions were not expressed directly, so being naturally quiet, you may have learned to withdraw in the face of conflict and keep your feelings to yourself. Currently, you appear to be experiencing some physical symptoms that are hard to diagnose fully and cause you some anxiety. You may benefit from learning how to recognize what you are feeling so you could learn to express it better to others. Notice if your physical symptoms increase in intensity when you are troubled by stressful issues and learn relaxation and deep breathing techniques. Mindfulness training can also be helpful to you, as you may have a tendency to become lost in your own thoughts.

Scale 2: Depression (D)

Descriptors

Complaints

Depression, anxiety, dissatisfaction with life, sleep disturbance, gastrointestinal complaints, concerns over poor health, low energy, difficulty starting to do things, problems with attention, concentration, memory, poor appetite, weight change

Thoughts

Loss of interest, loss of hope, pessimistic, guilty, self-derecating, worrying, nervous, thoughts of death or suicide, indecisive

Emotions

Anhedonia, depressed, hopeless, overwhelmed

Traits and Behaviors

Depressed, withdrawn, hyperresponsible, tense, insecure, low motivation, conflict avoidant

(Levak, Siegel, Nichols, & Stolberg, 2011)

Therapist's Notes

Scale 2 in the normal range reflects thoughtful, circumspect individuals who take their responsibilities and life in general seriously. They are not risk takers, and are prone to worry. When things go wrong, they readily feel guilty and can occasionally lose sleep when faced with stress or a difficult decision. When Scale 2 is elevated above a T-score of 65, Scale 2 is an excellent measure of current symptomatic depression. Scale 2 elevated when the other clinical scales are below a T-score of 65 is known as a "Spike-2" profile. It reflects a depression uncomplicated by personality disorders, damaged identity, or thought disorder symptomatology. This type of depression is amenable to treatment with a combination of cognitive, behavioral, and chemotherapies. Elevations on Scale 2 are associated with the typical symptoms of depression: sad mood, feelings of inadequacy, general inefficiency, low morale, guilt, anxiety, social withdrawal, passivity, conflict avoidance and, in some cases, obsessive-compulsive thoughts and

behaviors. These clients often feel hopeless, pessimistic, and fearful of taking emotional or behavioral risks. Scale 2 can also indicate vegetative symptoms of depression such as altered appetite, weight change, disturbed sleep, and difficulties with attention, concentration, and memory. Individuals with a high score on this scale may have experienced an actual or perceived loss, which has left them fearful to engage in life, perhaps out of fear of experiencing further loss. Sometimes the loss associated with Scale 2 elevations occurred in childhood, resulting from an overload of responsibilities, restricted opportunities for carefree play and normal unfettered learning, and diverse socialization. In other cases, the depression is associated with early parental death, parental withdrawal, or other losses such as poverty and prejudice (Speisman, 2006). Typically, high Scale 2 individuals blame themselves for their losses and experience a pervasive sense of guilt. Our hypothesis is that inhibiting hope, motivation, and general drive as a way to protect against further loss is an adaptive response to such loss. In this context, pessimism and negativity can be viewed as protective.

Scale 2 also reflects personality traits such as hyperresponsibility, perfectionism, and a tendency toward intropunitiveness, which can predispose individuals to depression when losses occur. Sometimes a Scale 2 score significantly below a T-score of 50 with an elevated Scale 9 reflects the manic phase of a bipolar disorder. A low Scale 2 in the presence of a normal profile, with no clinical scales elevated above 55, may reflect a positive, optimistic, and resilient person who deals well with losses and setback.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Lifestyle and Family Background

Elevations on Scale 2 are associated with a lifestyle of conscientiousness, guilt, and self-doubt, with a tendency toward taking on responsibilities. These individuals present as depressed and experience difficulty celebrating life, even when things go well. Friends and family members may see them as critical and negative because of their tendency to focus on what can go wrong. From their perspective, such negativity can be seen as an effort to protect others from loss rather than being critically intended. Reactive depressions would be associated with some actual or perceived recent loss but with a history of resiliency and no depression. The depression would be more endogenous with a history of hopelessness, early childhood deprivations, or losses and a lifestyle of hyperresponsibility and self-negation.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Spike 2 occurs when Scale 2 is the only scale elevated beyond *T*-65. It reflects a current depression, which may be reactive or chronic. Typically, the person feels sad and unhappy, inadequate, lacking in self-confidence, and is often anxious, self-critical, and quick to feel guilty. These individuals experience the typical symptoms of depression,

including disturbances in sleep, appetite, sex drive, concentration, and memory. They can be self-punishing and self-defeating. The relative elevations on the depression subscales help to identify which depressive symptoms are the most troubling and need immediate treatment. Spike 2 individuals tend to be serious, highly responsible, and acquiescing. This is especially true if no other scales are significantly elevated. In college students, Spike 2 profiles may reflect concern with relations with the opposite gender, learning issues, or vocational choices. Although suicide cannot be predicted by the MMPI-2 alone, responses to Items 150, 303, 506, 520, 524, and 530 on the MMPI-2 are significant because they refer directly to suicidal ideation, plans and/or suicide attempts. In some cases the Spike 2 codetype is stable; the individual has come to terms with the depression and may not even be aware of how depressed he or she is. The prognosis for a Spike 2 profile is generally good, since these individuals often respond well to medication and to a directive approach helping them to grieve past losses.

- Mild to moderate dysphoria with sad affect and complaints of inefficiency, irritability, and a loss of interest, self-confidence, and pleasure in living. Depression may be minimized or denied. May complain of anergia and be self-critical, especially as an overreaction to perceived mistakes, or personal faults. Guilt and intropunitiveness; passivity and underassertiveness. Look for recent loss or setback (i.e., reactive elements).

Black found only one term significantly related to an MMPI peak score on 2 in the descriptions of this group of college women furnished by others: shy. In these descriptions, there were also several terms that were omitted significantly from the checklists. These adjectives included cheerful and flattering, curious, energetic and courageous, kind, laughterful, peaceable, relaxed and frank, self-confident and independent, self-denying, sociable, and cooperative. When Black tabulated the adjectives that the high 2 subjects checked about themselves, however, he found a more adequate basis for characterizing their self-concepts. The picture was one of self-depreciation and inadequacy. Included in the self-descriptions were these terms: affected, aloof, indecisive, moody, neurotic, quiet, secretive, self-dissatisfied, self-distrusting, shy, unself-controlled, and worrying. In addition, these high 2 girls omitted (at a statistically stable level) a number of adjectives in their self-descriptions:

aggressive, cheerful, contented, courageous, decisive, energetic, friendly, independent, laughterful, lively, poised, practical, self-confident, and talkative. Mello and Guthrie found that counselees from a college population frequently presented a profile with scale 2 as the peak. In this age group, high points on 2 seem to reflect disturbance over situational problems in the college setting. That is, these young people did not show the typical tearful depression associated with this pattern in adult groups, but rather were troubled by problems involving relations with the opposite sex, studying, or vocational choice. While in therapy these young people resisted efforts of the therapist to go deeply into the origins of their problems; they used intellectualized statements or often-repeated descriptions of

their problems to keep the therapy superficial. When the situational pressures let up, these counselees discontinued treatment quickly, nearly half of them having only between one and three contacts with the center. They regarded the counseling situation as an opportunity to seek advice from a parent surrogate at a time when they were faced with insurmountable problems. They did not readily form dependent relationships with the therapist, however, doing so only if they had several contacts. The medical patients in Guthrie's group who had peak scores on scale 2 showed, as might be expected, a high incidence of depression with some physical symptoms, but these were not prominent or varied. A mixture of depression and severe physical distress was found in some patients and was related to certain subordinate peaks in the profile, as noted below. This total group of patients showed rather poor response to treatment. It is difficult to tell whether this prognostic picture reflects primarily the fact that these patients are of a somewhat different sort from the cases of depression seen in a psychiatric setting or whether it reflects the ineffectuality of regular medical procedures used by an internist as contrasted with traditional psychiatric measures. Guthrie found that when scale 2 was the only codable scale (in the Hathaway coding system) and the low point was on scale 9, the depression was mild and the physical complaints were rather typically centered around fatigue and loss of energy. These moderate physical complaints yielded rather easily to reassurance and symptomatic treatment. Occasionally a period of mild overactivity was reported to have occurred before the depressive symptoms appeared. Drake has noted that college counselees characterized as unhappy or depressed tend to have peak scores on scale 2 and that these features appear intensified when scales 0, 7, and 8 are also elevated. Significantly absent from the peak 2 group were students judged to be lacking in academic motivation.

(Dahlstrom, Welsh, & Dahlstrom, 1979)

Descriptions:

Sometimes depression developed out of inability to deal with aggression, rage outbursts, are introverted and reserved

Possible Diagnoses:

Reactive depression

Modifying Scales

- The Harris-Lingoes subscales tend to be uniformly elevated when the clinical Scale 2 is highly elevated. The relative contribution of the various subscales helps describe the more extreme and palpable features of the depression. If Psychomotor Retardation (D2) is low and Psychomotor Acceleration (Ma2) is elevated, the depression may be agitated. Energizing antidepressants may lead to self-defeating or self-destructive acts or a manic episode.

- The Depression (DEP) and Low Positive Emotions (RC2) scale consists of almost all obvious items, suggesting that these clients are actively complaining about depression. If Scale 2 is elevated but DEP and RC2 are not, the depression may be manifested in vegetative symptoms and may be less clinically obvious than when DEP and RC2 are also elevated.
- Elevations on the Schizophrenia (Sc) subscales, especially Lack of Ego Mastery Cognitive (Sc3) reflect the degree of cognitive impairment. Lack of Ego Mastery Cognitive (Sc4) would predict greater inefficiency and impaired drive.
- Elevations on Emotional Alienation (PD5) may reflect guilt.
- Elevations on Authority Problems (Pd2) may reflect anger, passive-aggressive behavior, and self-defeating behavior.

(Levak, Siegel, Nichols, & Stolberg, 2011)

>80 - check for suicidal ideation, severe depression

75-85 - moderate depression, 65-75 - mild unhappy, low self-esteem, helplessness, hopelessness - depression, withdrawal, psychomotor retardation

D1 - Subjective depression - agitation, meaninglessness, insecurity, low self-esteem

D2 - Psychomotor retardation - immobilized, socially avoidant, motorically slow, deny hostility

D3 - Physical malfunctioning - preoccupation with physical symptoms

D4 - Mental dullness - memory/concentration problems, lack of energy, hopelessness, helplessness

D5 - Brooding - ruminative, unable to control intrusive thoughts, irritable, sensitive to criticism, lack meaning

Male

Nothing Low Introverted or self-conscious or socially insecure, lacks skills with the opposite sex, tense, unhappy, worries a great deal, insomnia.

Female

Low 0 Tense on examinations,

Low 1 Lacks self-confidence, physical inferiority.

Low 4 Lacks self-confidence.

Low 5 Anxieties, nervous, depressed, indecisive, wants answers, tense on examinations, socially shy, lacks skills with the opposite sex, socially insecure.

Low 6 Lacks self-confidence, nonverbal, socially insecure.

Low 9 Mother conflict.

Nothing Low Depressed, lacks skills with the opposite sex.

(Drake & Oetting, 1959)

o **Check:** *HEA3, DEP, DEP1, DEP2, DEP3, DEP4, RC2, INTR, AGGR* (low), *Dr1, Dr2, Dr3, Dr4, Dr5, Hy3, Hy4, Pa1, Sc4, Ma* (low), *Ma1* (low), *Ma2* (low), *Ma3* (low), *Ma4* (low).

norm - comfortable, gregarious, active, alert, enthusiastic

very low - lack of impulse control, conflict with societal values, manic state

TREATMENT

There are several well-researched treatments for simple depressive disorders. Insight therapy, cognitive restructuring, psychotropic medication, assertiveness training, relaxation training, self-esteem building, and dealing with grief over past losses are all useful therapeutic modalities. (See also treatment section under the Spike 2, low Scale 9 codes.)

o **Treatment:** Rule out Major Depression. Evaluate suicidal ideation. Generally responsive to a broad range of treatments, including reassurance, advice, assertiveness training, exercise, and formal psychotherapy.

Therapy and Therapeutic Pitfalls

Scale 2 elevated when other clinical scales are below a T-score of 65 is an uncomplicated depression. A spike 2 depression involves an internal sense of loss and a feeling of being inadequate. For the high Scale 2, being engaged in a healing, supportive, loving relationship can be therapeutic because these clients do not manifest other self-defeating defenses. This profile is associated with generally favorable treatment outcomes. In all diagnoses of depression, however, assess for suicide risk.

Antidepressant medications often provide relatively prompt relief, especially when the depression is severe.

Cognitive-behavioral therapy (CBT) has been well researched as an effective treatment for depression (Dobson, 1989; Hollon, Thase, & Markowitz, 2002). Assertiveness training (Langone, 1979), and interpersonal therapy (Klerman, Markowitz, & Weissman, 2000) are also useful. Exercise, a healthy diet, and avoiding alcohol can also be effective in alleviating depression (Ilardi, 2009).

These individuals have experienced an actual or perceived loss and have not fully engaged it and resisted their mourning process. The therapist should avoid the temptation to prematurely reassure and “persuade” clients to see the “positives” in their lives, as that may have the paradoxical effect of creating resistance. Explore how past goals

and desires have been a disappointment, and help clients express the anger and sadness associated with losses to facilitate the mourning process.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Treatment and Self-Help Suggestions

1. Your doctor may want to consider medication, which could help you feel better quickly.
 2. Research has shown that regular aerobic exercise can decrease stress and can have a very positive effect in relieving depression.¹
 3. Work with your therapist to change how you view yourself. Notice how quick you are to blame and doubt yourself. In any given moment, when you dislike yourself, attempt to make a list of your positive attributes so that you maintain a balanced view of yourself.
 4. Resilience building: Assertiveness training can be an effective component of mood regulation.² *Assertiveness* is an honest and direct expression of your own desires and thoughts while still respecting the thoughts and feelings of others. An *aggressive* response ignores the feelings of others, whereas a *passive* response is the failure to express your own wants and needs. Think of examples either in your own life or something you have observed that illustrates different styles of communication, and then role play assertive responses with your therapist.
 5. Identify with your therapist what you perceive as past or recent losses. Find ways to forgive yourself for these setbacks and losses so that you can stop beating yourself up for them. Learn to express anger about those losses without self-blame.
 6. Feeling depressed can be quite lonely and isolating, but one of the best ways to start to feel better is to reach out for social support and contact. Consider making plans with friends or family, even if it is just by phone or for a brief visit. You may also consider joining a support group for depression. Many are offered at low to no cost and can be found by searching the Internet for depression support groups in your area. Joining a sports team is another way to seek out social support while concurrently getting the benefits of exercise.³
 7. Resilience building: Learning an optimistic (yet realistic) viewpoint can contribute to a more hopeful outlook on life and to better self-esteem. Optimists explain difficulties as *temporary*, *nonpersonal*, and *specific*, whereas pessimists explain them as *permanent*, *personal*, and *pervasive*. For example, in a relationship problem the pessimistic explanation would be, “I’m unlovable” (personal, permanent, and pervasive), whereas an optimistic explanation would be, “We have both been under stress lately” (nonpersonal, temporary, and specific). Practice learning this new way of explaining difficulties.⁴
-

¹ While the literature on physical exercise and depression has been confusing, with both positive and negative effects being reported, cross sectional and longitudinal studies indicate that aerobic exercise has antidepressant and anxiolytic effects and protects against the harmful consequences of stress (Salmon, 2001).

² Many everyday problems with stress and emotional regulation can be directly attributed to interpersonal problems such as conflict with coworkers, coping with roommates or loved ones, or trouble with authority figures. Learning to communicate assertively is a cornerstone of more effective and satisfying interactions and subsequent improvements in mood (Smith, 2002).

³ Studies have determined that not only is loneliness a by-product of depression but also that it contributes to the symptoms of depression. Learning skills to increase social support can help (Eisemann, 1984). It is important to note that, especially for adolescents, sports participation is a powerful shield against depression and suicidal ideation for teenagers, with the odds of suffering from depression decreasing by 25% as sports participation increases (Babiss & Gangwisch, 2009).

⁴ Explanatory style is related to psychological health indices, self-esteem, and coping skills. Programs that change explanatory style help to prevent depressive symptoms in adults and children (Gillham, Reivich, Jaycox, & Seligman, 1995; Seligman, Schulman, deRubeis, & Hollon, 1999). (Levak, Siegel, Nichols, & Stolberg, 2011)

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests you are a responsible, dutiful person who takes life seriously. You are cautious, avoid risk, and tend to be your own worst critic. You are quick to feel guilty and you tend to avoid celebrating your accomplishments. Currently you may be feeling quite sad and unhappy, even despondent and depressed. Perhaps a recent loss or a series of setbacks has made you feel defeated, guilty, and down on yourself. You may be experiencing sleeping problems, feeling sluggish and tired, and having difficulty remembering and focusing. Your appetite and sex drive may be affected and you may feel unable to enjoy life. Talk with your therapist if you are feeling suicidal or feel a loss of your will to live. Sometimes people with this profile experienced childhood loss of some kind with an absence of childhood carefreeness. Talk to your therapist about recent and past losses and find ways to forgive yourself for them. Learn to switch off negative thoughts and try to avoid catastrophizing. Your tendency to avoid “wanting things” or “hoping for things” is an understandable response to having experienced a severe loss. To be negative and withdrawn and to lose hope is an understandable response to a loss that feels catastrophic. Learn to switch off some of your guilty feelings and maintain a gratitude journal to remind you that things may not be as

bleak as they sometimes feel. Your therapist may suggest medication to help you obtain restful sleep and increase your energy, appetite, and positive mood.

Feedback Statements—Elevated Profiles (T-Score > 65)

Depression, Dissatisfaction, Anxiety

Your profile shows that you are currently feeling quite down and depressed. Sometimes people with depression become used to it and no longer realize how depressed they are; in other cases, people experience great discomfort. Often when people get depressed, they also become anxious. They experience this anxiety as a constant sense of dread, as if something bad is about to happen.

Sleep Disturbance, Poor Health, Weight Change

Typically, people with your profile have difficulties sleeping. In some cases, it is difficulty falling asleep because your mind is agitated and you are unable to switch it off. In other cases, people with this profile can fall asleep, but then they awaken early in the morning and are unable to return to sleep.

When people become depressed, they often complain of physical symptoms. Stomach upsets and difficulties with elimination are typical. You may also experience fluctuation in weight. You may find that you no longer enjoy foods that once tasted good to you. You may find preparing food tedious, and you may have lost enjoyment in eating.

Non-confrontational

People with your profile tend to avoid confrontation. This may be because you doubt yourself and you tend to blame yourself if someone upsets you. It may also be hard to confront others because you lack the energy and confidence. You tend to worry that you don't have the right to ask for what you want or to tell others off.

Low Energy

When people are depressed, they often feel a lack of energy and low motivation. Things that, in the past, seemed to take little energy now may seem overwhelming. You may have to push yourself to engage in even the simplest activities that others might find pleasurable. You may find yourself dreading doing even the smallest chores.

Problems With Attention, Concentration, Memory

Depression is associated with difficulties with concentration, memory, and general alertness and attention. You may reread the same thing without comprehending it, and you may be unable to remember what you did earlier in the

day or the day before. You may even become fearful that you are somehow losing your mind. Generally, these symptoms decrease once the depression is treated.

Loss of Hope or Pessimism

Depression is often associated with a loss of hope. You may give up hopes and dreams for the future, feeling that it is useless to have desires because you are likely to be disappointed. People may see you as pessimistic, but this reflects your fear that your life is over and your feeling that the future is bleak.

Feelings of Guilt

People with your profile tend to experience a great deal of guilt. Perhaps some recent setback or past losses have left you with feelings of self-blame, feeling that you have ruined your life and that your failures are unforgivable.

Guilt is a painful companion as you remind yourself of your failures. Even if you do something well or if people say positive things toward you, you may feel guilty as if you do not deserve compliments.

Feelings of Hopelessness, Thoughts of Death or Suicide

Most of the time, you feel a sense of hopelessness, so little in the future gives you joy. Having nothing to look forward to can be quite distressing. You might have given up planning ahead, feeling that nothing will give you pleasure. People with your profile can become very aware of the possibility of death and decline, and sometimes they become preoccupied with thoughts of killing themselves. This is something that you should openly discuss with your therapist.

Lifestyle and Background Feedback

Typically, people with your profile have experienced recent or past losses that have left them apprehensive about allowing themselves to enjoy life. Perhaps as a child you experienced the loss of a parent figure, leaving you with overloads of responsibility, or for some other reason you may have been deprived of the normal joys of a carefree childhood. In other cases, recent losses, perhaps a job, a blow to your self-esteem, or a perceived or actual setback, have made you feel hopeless about ever enjoying life again. Being negative, pessimistic, and withdrawing from life may be an understandable self-protection from further loss or setback.

Normal-Range Feedback Low Ranges (T-Score < 50)

You are a person who generally stays positive and optimistic, and you have steady and available energy. Things rarely get you down for very long, and you bounce back easily from adversity. Your view of life may be that people

can solve their own problems if they work hard. You are able to focus on tasks at hand and are generally free of anxious and depressed thoughts.

Average Ranges (T-Score 50 to 65)

Your profile is within the normal range. It shows that you are a serious and thoughtful person who takes responsibilities seriously. You shy away from taking unnecessary risks, and you are cautious about “counting your chickens before they hatch.” You are an earnest person, realistic about life’s ups and downs. Recently, you may have experienced a minor setback, which has left you feeling careful about being too optimistic in case something goes wrong again. Sometimes people with this profile grew up having had more responsibility than is normal for a young child. Perhaps you were in a caretaker role, either for a younger sibling or even a sick parent or family member. (Levak, Siegel, Nichols, & Stolberg, 2011)

Spike 2, Low 9 Code

All of the descriptors for Spike 2 apply to this profile with some additions. When Scale 2 is elevated, no other clinical scales are significantly elevated, and Scale 9 is below *T*-45, fatigue, low energy, lack of assertiveness, and a quickness to “give up” in the face of obstacles is even more pronounced. These individuals are serious, circumspect people who guard their energy resources carefully. Increased complaints of low energy, feeling easily fatigued and overwhelmed as well as a lack of willful assertiveness would be suggested by the low Scale 9. If Scale 4 is at or below *T*-50, low aggressiveness, low sex drive, and a rigid adherence to rules, regulations, duty, and responsibilities are likely.

TREATMENT

Cognitive restructuring, directive approaches, relaxation training, psychotropic medications, and finishing of grieving over past losses are all effective therapeutic strategies. These individuals follow instructions well because they are so responsible.

Transference usually involves their feelings of guilt for not progressing enough, with accompanying fears of therapist impatience or abandonment.

Energizing antidepressants may be indicated for a Spike 2, low 9 codetype, though medication effects may be experienced as uncomfortable, since the profile suggests an acceptance of a high degree of unhappiness and a slow pace. Consequently, medication should be prescribed in small incremental doses, so the patient can habituate to changes in mood state and energy level.

A Spike 2, low 9 codetype may indicate the depressive phase of a bipolar disorder, so the diagnosis would need to be confirmed through a clinical history. Childhood experiences of overloads of responsibility and deficits of age-appropriate carefreeness would not be atypical for Spike 2 profile. Hyper-responsible, they may have experienced

childhoods where they were expected to take on adult roles beyond their years. Helping the patient engage anger over past losses can be useful, though they would tend to avoid expressing anger towards loved ones and are more comfortable expressing anger towards themselves. Cognitive restructuring, thought stopping, relaxation training, and assertiveness training are all useful treatment modalities. Help them set up a self-reinforcement schedule after completion of their responsibilities to teach them how to celebrate their accomplishments.

THERAPEUTIC FEEDBACK LANGUAGE

Language would be the same as the Spike 2, with the following addition: Your profile suggests that your energy is currently particularly low, so even small tasks and duties take a great deal of effort. You likely resist demands on your energy and avoid taking on too much, even if some of the activities could be seen as pleasurable. Your weight may increase in response to your lowered energy level.

21/12 Code

The interpretation of the 21 codetype is similar to that of the 12 codetype, except that complaints of depression and anxiety are more prominent. These individuals feel burdened, tired, defeated, misunderstood, and underappreciated. They feel a sense of moral superiority because they suffer and sacrifice for their family. Others, especially family members, feel guilty because they are the focus of the 21 individual's concerns and worries. Acting out is rare, unless Scale 4 is elevated third, and then it is passive-aggressive and self-defeating. These individuals tend to have a strong work ethic, often reflected in a puritanical, self-sacrificing lifestyle. Oral-dependent and sometimes alcoholic, these individuals complain of many of the physical symptoms associated with a 12 codetype, but verbalize more of the depressive symptoms that manifest themselves as pessimism and unhappiness, rather than specific complaints about physical symptoms, which are primary for the 12 individual. This codetype is more common among men than women.

21s

Among male psychiatric groups, this code pattern is the second most frequent combination of high points, and in the outpatient data reported by Sundberg (1952; see Appendix M, Tables 11 and 12), this is the most frequent male pattern. Among normals, however, the pattern seems to be more frequent in women, although it is not a prominent one in any of the normal groups. From what is now known about the role of scale 1, the prevalence of this pattern in Guthrie's (see Appendix M, Tables 15 and 16) groups of medical patients is quite understandable. Empirical data on this particular code come largely from Guthrie's findings. In his analysis of the MMPI configurations, Guthrie found

that the 21s and the 23's were very similar. He pointed out, however, that the males in the 21 code group presented a somewhat different clinical picture from that of the females. The males showed either depression and tension or a very delimited physical complaint, generally concentrated in the upper gastrointestinal tract. Few had the multiple complaints of the 12's, and for few was there any physical basis for their problems. Sullivan and Welsh (1952), it may be noted, found this pattern and the 12 pattern related to an ulcer condition in male Veterans Administration patients, but only two cases in Guthrie's group had active ulcers at the time they were seen by the internist. His male subjects were described as immature and generally inadequate, although not clearly hypochondriacal like the 21 females. They showed varied responses to treatment that appeared less related to their symptom pictures than to the length of time they had experienced their difficulties. The high 21 women in Guthrie's study, although having some tendency to concentrate on epigastric pains, showed hypochondriacal patterns with a wide range of physical symptoms and an even greater concentration upon tension and depression. Their depression was accompanied by restlessness rather than apathy. They described themselves as suffering from a loss of initiative, from dysphoria, and even occasionally from dizziness and from fear. No alcoholism or acting out appeared in their backgrounds. Guthrie also characterized these women as able or willing to tolerate high levels of discomfort and therefore rather poor therapeutic prospects. These descriptions are consistent with the finding of Hovey (1949) that this pattern on the MMPI was the typical configuration of anxiety reactions. The items that Guthrie found characteristic of the 21 group were largely somatic and mood items from scales 1 and 2 (see the Co21 scale in Appendix I in Volume II). A significant number of them were ruminative and dysphoric items from scales 7 and 8 as well as personal sensitivity items (scored oppositely on scale 4). Note that further data on the 21 pattern are reported in Marks and Seeman's 231-213 code type.

(Dahlstrom, Welsh, & Dahlstrom, 1979)

TREATMENT

See also treatment section under the 12 code. With Scale 2 elevated above Scale 1, some individuals may complain more of depressive features and be more amenable to working on finishing grieving over past losses. Others with this codetype, however, may feel defeated about their condition and therefore less motivated or trusting of the therapy process, even though they experience severe distress. Gestalt therapy to help clients express their somatic complaints through role-playing can be effective. For example, "having their symptoms do the talking" can offer them a chance to express repressed anger and sadness. Medication is often effective, but needs to be presented as a way to help them deal with their "exhaustion" due to their physical symptoms, rather than due to psychological "problems."

Assertiveness training, relaxation training, and thought stopping are also useful.

THERAPEUTIC FEEDBACK LANGUAGE

See also therapeutic feedback language section under the 12 codetype. Your profile suggests that you are currently feeling down, unhappy, blue, and concerned about your physical symptoms. You are a thoughtful, responsible, and dutiful individual, and you dedicate yourself to your career and your responsibilities. You may feel others do not appreciate how much you sacrifice for them and how hard you work for others without enough reward. Currently you may be experiencing a number of physical symptoms that concern you and rob you of pleasure. Perhaps growing up you had to be dutiful and responsible because a parent was somehow unavailable due to illness or death. From an early age you learned to sacrifice yourself for others and you have continued to put responsibility and caring for others above yourself. Currently, you appear to feel somewhat worn out and exhausted, and your body is taking the strain. Your therapist may want to give you some medication to help you sleep, feel more rested, and feel more energized. Dealing with your current depression may actually help some of your physical symptoms decrease in intensity. Make a diary of when your physical symptoms are worse and examine whether you are experiencing greater stress during these times. Take a relaxation class, a mindfulness class, or perhaps yoga as a way of helping you relax. Watch your tendency to catastrophize and to see things from a negative perspective. Allow yourself to be assertive, to ask for what you want, and do not sacrifice yourself for others so much. Forgive yourself for any past losses and allow yourself to switch off your tendency to feel excessively guilty for your past mistakes.

213/231 Codes (see also 123/213 Codes)

Although interpretation of this codetype is similar to the 21/12 codetype, the elevation of Scale 3 adds other defenses, such as repression, denial, and strong needs for approval from others. These clients manifest depression and preoccupation with bodily damage, often complaining of headaches as well as chest pain, nausea, vomiting, and other vague and shifting physical symptoms. These symptoms are frightening to them and they become easily concerned about the possibility of dying due to unexplained illness. Their depressive symptomatology may, however, manifest itself as a “smiling depression,” where laughing and crying at the same time manifests sadness but also their need to be pleasing to others. Anger tends to be denied, and expressing any emotion that can lead to criticism is inhibited. They have strong needs for affection, affirmation, and approval. They fear loss and abandonment, and elicit attachment responses by being self-sacrificing, but also needy and complaining. Because they are so fearful about their physical symptoms, they want others to show sympathy and support, but their demands for reassurance can become annoying to others, leading to further insecurity.

Typical symptoms are of depression, which they see as the result of poor health. Sleep and eating problems, loss of libido, and difficulties with concentration and memory are also typical. They are more likely to complain of depression as secondary to their physical concerns. They tend to be tense, nervous individuals, concerned about how

others see them. Nausea or vomiting, weight loss, heart palpitations, chest pains, and forgetfulness are common. Sometimes there may be a cyclical character to these individuals' complaints. The hysterical defenses associated with Scale 3 elevations appear to operate intermittently, so that the individual may go from being outwardly smiling, pleasing and well-functioning, to being incapacitated by depression and anxiety over physical decline. Initially, the therapist may diagnose the individual as suffering from a cyclothymic disorder, but the mood swings reflect the operation of hysterical defenses and related "flights into health," followed by periods of depression and gloominess should the hysterical defenses collapse, and the patient may be overcome with fears of physical illness and decline. Genuine somatic breakdown due to years of stress and tension is typical with this profile. The individual's response to stress leads to physical breakdown, which then becomes their primary concern, leaving them less likely to tackle the psychological sources of their somatic problems/illnesses. When Scale 7 is also elevated, anxiety and worry are greater. Histories of indifference or outright rejection from parent figures and/or traumatic loss through the death or divorce of one of their parents during childhood is typical. Childhoods are typically characterized by social participation rather than withdrawal and, especially if Scale 4 is low, they live responsible lives. They are often highly conscientious and self-sacrificing, and therefore have a tendency to induce guilt in others. As parents, they are very giving toward their families and often feel unappreciated. They do not consciously manipulate others into caring for them, but because of their early experiences of abandonment, they tend to become co-dependent and others readily take advantage of them. Consequently, they feel unloved, unappreciated, and taken for granted. Family members act out, perhaps in reaction to the 213 individual's tendency to be controlling and demanding.

2-1-3 See the 2-3-1 combination, point 3, p. 102; also point 1a in the 2-1-3/2-3-1 Triad profile, Figure 14, p. 135

- This pattern was found in a group of male alcoholics. Also found were the 2-4-7, 4-9, and 8-7-6 patterns (Conley, 1981).

TREATMENT

These individuals exhibit approach-avoidance conflicts in their primary relationships. Although they are dependent and want nurturing and emotional affirmation, they fear emotional abandonment so they can appear petulant, manipulating others into taking care of them due to their physical infirmities. Look for childhood histories of an early death of a parent and/or experiences of rejection or emotional withdrawal from a father figure. In the presence of such a history, these individuals may repeat their childhood experiences of craving emotional support from a nurturing figure, perhaps the therapist, but at the same time fearing abandonment from the therapist. They would seek to try to please the therapist, but fear the therapist becoming impatient and abandoning them. Insight therapy

will not move quickly because of their tendency to deny the intensity of early childhood trauma or parental unavailability. Pushing by the therapist could lead to premature termination because it engages too intense an emotional reaction. It would be important in therapy to “go with the resistance” by validating how loving and supportive their caregivers were, but also allowing the patients to develop empathy for themselves around their early losses. Emotional catharsis can be helpful if approached gradually. Sometimes having them imagine their childhood experiences as occurring to somebody else or to one of their children can help them develop empathy for themselves, which they tend to resist since it engages frightening feelings. Relaxation training, assertiveness training, and catharsis around past losses, as well as teaching them to recognize and express anger, are helpful therapeutic strategies. Both the anger and sadness aspects of the mourning process are often blocked in this codetype. The individual has adapted to early rejection and losses by being “brave,” “a good soldier,” nice and acceptable to others, smiling in spite of pain, and preoccupied with avoiding further rejection. Sometimes a “flight into health” occurs and therapy is terminated. If, during therapy, the patient begins to criticize their past therapists, they may be unconsciously venting frustration with their current therapist. Helping them to express resentment towards their current therapist could help not only model how the expression of anger and resentment need not lead to loss, but to more effective ways of expressing anger. These individuals are highly conscientious, so they are often seen as good workers, but eventually can irritate coworkers because of their taking time off due to physical complaints and their tendency to be somewhat self-sacrificing and consequently resentful. In this way, their conscientiousness backfires, as others feel they have been made to feel guilty. As in any depression codetype, suicide assessment is important. Antidepressant medications are useful, as are insight therapy, venting, and catharsis.

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you are a dutiful, responsible individual who works hard to stay positive and please others. In some cases, people with your profile experienced early childhood deprivations or losses, so that they weren't able to be as carefree and feel as secure as many children expect to be. Perhaps you experienced a parent dying or being unavailable at an early age, and you learned that you needed to be brave, to smile through your difficulties, and to be “a good soldier.” You have continued to go through life protecting yourself against disappointment and loss by not “counting your blessings,” but by always being aware of what can go wrong. Your profile shows that currently you are experiencing a number of physical symptoms of stress. Headache, backache, stomach upset, feeling nauseous, and vague and shifting physical symptoms such as headache, backache, unexplained stomach upset, and nausea may cause you a great deal of anxiety. Perhaps you've become afraid that these physical symptoms will worsen and lead to infirmity or even death. At times you can smile through your difficulties, but at other times your emotions break through and you feel overwhelmed by sadness, loss, and despair. The profile suggests that you are experiencing a

current depression that may be masked to others because you are trying so hard to be brave and positive. Beneath your smile you worry that people may reject or abandon you, and that you are not good enough unless you sacrifice yourself for others. A therapist may want to give you some medicine to help you sleep better, regulate your appetite, and to help you concentrate and think more clearly. Work at being more assertive and learning to ask for what you want. Work with your therapist to avoid being co-dependent with others who can take advantage of you. Talk about any past losses you experienced, perhaps of self-esteem or of child-appropriate carefreeness. Work to switch off guilty feelings that overwhelm you and try to make a gratitude list to help you realize the positive things in your life so you do not focus on the losses.

23/32 Code

Code-Type 2-3/3-2

Descriptors

Complaints

Physical illness (gastrointestinal problems, musculoskeletal problems, cardiovascular problems, headaches, nausea, vomiting, chest pain, fatigue, weakness, neurological symptoms, weight loss), memory and concentration difficulties, depression or sad mood, constant worrying, low sex drive

Thoughts

Morbid or sad, preoccupied with physical decline, self-deprecating, selfpunishing, worrying, pessimistic about treatment, guilty

Emotions

Depressed, anxious, overly sensitive, brave, inhibited

Traits and Behaviors

Dependent, inhibited, somatizing, insecure, conflicted about self-assertion versus dependency, possible alcoholism

(Levak, Siegel, Nichols, & Stolberg, 2011)

Therapist's Notes

When the 2-3 code-type scores are in the average to moderate range, it represents a tendency to be respectful, dutiful, and self-sacrificing. People with this score lack assertiveness and have difficulty standing up for themselves. Elevated profiles are associated with severe depressive symptoms masked by somatization and hysterical defenses. The 2-3 individuals have strong needs for affection, attention, love, and reassurance. Solicitous of others and self-sacrificing, they are unable to be reassured by others' love and attention, partly because their self-sacrificing behavior is a role play and partly because it induces guilt in others. This is a somatizing depression in which feelings of anxiety, tension, worry, insecurity, and fear of being rejected and unloved are mostly unconscious. Physical symptoms and panic about a decline in health tend to be a focus. Headaches, stomach upsets, musculoskeletal complaints, various tingling, weaknesses, and other somatic symptoms reflect their repression of emotion, with resulting tension and somatic involvement. These individuals tend to be intro-punitive: quick to blame themselves rather than to externalize. Their tendency to be self-sacrificing, even when others do not ask for it, leads to others resenting them and feeling controlled by them. They repress and inhibit aggressive and sexual impulses, as if stuck in a childhood role of trying to be "good" to avoid rejection and abandonment. They are worried about what others think of them and crave approval and love, yet they find themselves unable to feel secure even when appreciation is given. The Scale 3 elevation suggests the active seeking of emotional connection and the denial of aggressive and sexual impulses. The elevation on Scale 2 suggests depression, guilt, anxiety, and low self-esteem. Given their denial and inhibition, it is not surprising that this has been called a "smiling depression" because of their tendency to smile through their tears. These individuals are conventional, respectful, dutiful, and self-sacrificing. Even though others would see them as demanding, this tends to be subtle and a reflection of their insatiable neediness and fear of emotional deprivation.

When Scale 3 is significantly elevated above Scale 2, the depression may not be recognized by the clients. In many cases, these individuals are very focused on physical symptoms and do not complain of feeling depressed. In some cases, individuals will search for alternative medicine solutions, sometimes becoming preoccupied with unusual treatments. Side effects from experimental treatments then aggravate the symptom picture, further complicating their understanding that depression is a primary problem.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Lifestyle and Family Background

Typically, 2-3 individuals experienced parental rejection and emotionally deprived childhoods. As children, they learned to please, to be brave, and to avoid conflict and confrontation. In research by Marks and Seeman (1963),

this profile was characterized by parental indifference, father rejection, and disrupted homes. A total of 55% had experienced a death in the immediate family. Marks, Seeman, and Haller (1974) found that the 2-3 is typically not the youngest child. Given the emotional deprivation, loss, and rejection, without the luxury of being an indulged youngest child, it is not surprising that a central issue for these clients is profound insecurity and fear of emotional abandonment. They crave approval and love and attempt to gain it through self-sacrifice. However, their self-sacrifice leaves them feeling deprived, and, unable to assert themselves, they develop hurt and resentful feelings. Even when they do obtain love and approval, it is hard for them to trust it. These individuals are extremely sensitive to rejection and are hyperresponsible. Any kind of criticism of their work or setbacks in their careers are experienced as potentially catastrophic because it means that they are less lovable and therefore vulnerable to more abandonment and rejection.

(Levak, Siegel, Nichols, & Stolberg, 2011)

The 23 codetype is more frequent in women. Characteristics of the 23 are depression, helplessness, apathy, fatigue, and somatic complaints, as well as emotional overcontrol and sleep disturbance, combined with a self-sacrificing, guilt-inducing lifestyle. Although Scale 1 may not be elevated the individual will complain of fatigue and vague somatic complaints, but without the intense preoccupation on physical concerns associated with Scale 1 elevations. The 23 individual is “bottled up” and consequently experiences associated physical symptoms. The combination of depression and hysteria leads to a dutiful, “nice” individual who exhibits a smiling depression, laughing and crying at the same time. Typical symptoms of depression such as low sex drive and difficulties with concentration and memory may be reported. Conflict is not expressed directly. Anxiety, when expressed, tends to be around displeasing others and somatic symptoms. Depression tends to be denied, so it is expressed as feelings of insecurity and a lack of capacity to enjoy life. These individuals generally have difficulty expressing negative emotions in any direct way. Their complaints may appear as somewhat vague dissatisfaction, unhappiness, and feelings of being unappreciated. They experience a great deal of stress around any confrontation and expression of anger. Repression and denial leaves them feeling weak, exhausted, and inefficient. Scale 9 below 50 would emphasize complaints of fatigue and low energy. These individuals are more likely to express feeling hurt, unappreciated, and unrecognized rather than expressing anger. They have learned to tolerate a high degree of unhappiness and accept that they function at a reduced level of efficiency. Though they may appear depressed, hysterical defenses may result in a pleasant, though somewhat flat, demeanor. The most frequent three-point codetypes are 231/321, 234/324, and 237/327.

People with 23 codetypes are achievement-oriented and feel a compulsive need to prove themselves. At the same time they feel that they are not recognized for their efforts. They seek out added responsibilities, which then burden

them. They crave recognition and love, but then fear failure and, with it, rejection. Marital problems may occur due to these individuals' low sex drive, and some women complain of physical pain during intercourse. Sometimes these individuals have a somewhat Victorian view of sexuality.

Although this codetype is more frequent among persons over age 25, it nonetheless occurs in adolescents and is associated with poor peer relations. These adolescents can complain of loneliness and social difficulties. Others may see them as passive, compliant, and obedient. Early childhood histories for 23 individuals in general often show an under-involved or rejecting father and an overinvolved mother. They were average, but anxious, students. Sexual acting out and drug abuse is not associated with this pattern for adolescents.

- o Much more frequent in women. Associated with so-called atypical depression/hysteroid dysphoria. Episodic dysphoric mood with crying and unhappiness; health concerns, fatigue, exhaustion, anxiety, insecurity, emotional overcontrol, and overreactiveness to stresses. May deny depression despite appearing manifestly unhappy. Problems with memory, concentration, and judgment, but without gross cognitive disruption. Disturbed sleep and loss of sexual interest. Conventional, conscientious, and responsible but dependent, avoidant, subassertive, and intropunitive, with self-depreciation and feelings of worthlessness, helplessness, hopelessness, and inadequacy. Excessive emotional control or constriction; feels "bottled up." Overly sensitive to criticism and rejection, but strongly inhibited in expressing aggression, anger, and mistrust. Others find them dependent, immature, self-sacrificing, and prone to martyrdom. Look for secondary or situational depression, interpersonal stresses such as marital conflict, recent losses/breakups in relationships, and sexual maladjustment.
- o Typically does not experience disabling anxiety but does feel nervous, tense, worried; sad, depressed; experiences fatigue, exhaustion, weakness; lacks interest and involvement in life situation; can't get started on things; decreased physical activity; gastrointestinal complaints
- o Passive, docile, dependent; self---doubts, inadequacy, insecurity, helplessness; elicits nurturance from others; interested in achievement, status, power; competitive, driven but afraid to place self in directly competitive situations; seeks increased responsibility but dreads pressure associated with it; feels he/ she doesn't get adequate recognition for accomplishments; hurt by even minor criticism

- o Over-controlled; can't express feelings; feels "bottled---up"; denies unacceptable impulses; avoids social involvement; feels especially uncomfortable around opposite sex; sexual maladjustment, including frigidity and impotence, is common
- o Functions at lowered level of efficiency for long periods; tolerates a great deal of unhappiness; usually diagnosed as depressive neurosis; not very responsive to psychotherapy; not introspective; lacks insight; resists psychological formulations of problems

Individuals with this high point pair typically show immaturity, feelings of inadequacy and insecurity, and inefficiency in living. Depression as well as lowered activity levels, feelings of helplessness, and self-doubt are evident. Initiative is lacking in clients with this high point pair and they are likely to rely on others to take care of them. They are viewed by others as rather passive, docile, and dependent. Feelings of social inadequacy are evident, resulting in a tendency to keep social contacts to a minimum. Such clients especially avoid competitive situations where failure might occur. They also are quite uncomfortable with members of the opposite sex, and sexual maladjustment, including impotence and frigidity, is common. Nevertheless, such individuals do elicit nurturant and helpful attitudes from others. Overcontrol is pronounced, as there is difficulty expressing angry and hostile feelings in a modulated, adaptive way. Instead clients with this high point pair deny experiencing these unacceptable feelings, but feel anxious and guilty when this denial fails. Somatic symptoms are present but often are inconsistent and changing. The prognosis in psychotherapy is guarded because these clients have learned to adjust to their somewhat chronic problems and have continued to function at low levels of efficiency for prolonged periods of time. Thus, their motivation for change typically is weak.

Symptoms and Behaviors

Persons with elevations on Scales 2 and 3 will be lacking in energy, weak, apathetic, listless, depressed, anxious, and frequently report gastrointestinal complaints. They feel inadequate and have difficulty accomplishing their daily activities. Much of their energy is invested in excessively controlling their feelings and behavior. Although situational stress may serve to increase their depression, usually this depression is longstanding, and they have learned to live with their unhappiness and general lack of satisfaction. They are not very involved or interested in life and experience a difficult time initiating activities. Some important male-female differences exist in the expression of this code type. Males are more ambitious, industrious, serious, and competitive, but also are immature and dependent. They strive for increased responsibilities, yet also fear them. They want to appear normal and receive recognition for

their accomplishments, yet they often feel ignored and their level of work adjustment is often inadequate. In contrast, females are more apathetic and weak, and experience significant levels of depression. They have usually resigned themselves to long-term unhappiness and a lack of satisfaction. Although there is often significant marital strife (check the FAM/Family Problems scale), they rarely seek divorce.

Affective disorders represent the most frequent category of diagnosis given to this code. Corresponding elevations on Scales 4, 6, and 0 may provide additional information relating to the personality of these persons. With a high Scale 4, there is more likely to be an angry, brooding component to their depression, with underlying antisocial thoughts, yet their external behavior is usually overcontrolled. An elevated Scale 6 suggests that their depression relates to extreme interpersonal sensitivity and distrust, whereas a high 0 indicates they are socially withdrawn and introspective. An additional diagnosis that should be considered is a major depression with psychotic features, especially if Scales 4 and/or 8 are also elevated. Many patients with this code type are diagnosed as having a somatoform disorder. A 23/32 code type is frequently seen with chronic pain patients, especially if Scale 1 is also elevated.

Personality and Interpersonal Characteristics

Individuals having this code type are often perceived as passive, docile, and dependent; therefore, they often obtain nurturance from others. By keeping their relationships superficial, they achieve a certain level of security. Their behavior often elicits nurturance from others. They are uncomfortable around members of the opposite sex and may experience sexual maladjustment, including impotence or frigidity. Interpersonally, they appear immature, childish, and socially inadequate. In terms of work, they feel the need to achieve and be successful, but are afraid of the added pressure this might produce. Although they might appear as if they are driven to succeed, they are anxious regarding competitive situations. Despite this avoidance of competition, they feel that their achievements are not adequately recognized.

23/32

Although persons with the 23/32 code type typically do not experience disabling anxiety, they report feeling nervous, agitated, tense, and worried. They also report feeling sad, unhappy, and depressed. Fatigue, exhaustion, and weakness are common. They lack interest and involvement in their life situations, and they have difficulty in getting started on a project. Decreased physical activity is likely, and somatic complaints, usually gastrointestinal in nature, may occur. 23/32 individuals are rather passive, docile, and dependent. They are plagued by self-doubts, and they harbor feelings of inadequacy, insecurity, and helplessness. They tend to elicit helping behaviors from other people.

However, persons with the 23/32 code type are very interested in achievement, status, and power. They may appear to be competitive, industrious, and driven, but they do not really place themselves in directly competitive situations where they might experience failure. They seek increased responsibility, but they dread the stress and pressure associated with it. They often feel that they do not get adequate recognition for their accomplishments, and they are easily hurt by even mild criticism.

23/32 persons are extremely overcontrolled. They have difficulty expressing their feelings, and they may feel bottled up much of the time. They tend to deny unacceptable impulses, and when denial fails they feel anxious and guilty. Persons with the 23/32 code type feel socially inadequate, and they tend to avoid social involvement. They are especially uncomfortable with members of the opposite sex, and sexual maladjustment, including frigidity and impotence, is common. The 23/32 code type is much more common for women than for men.

Rather than indicating incapacitating symptoms, it suggests a lowered level of efficiency for prolonged periods. Problems are long-standing, and the 23/32 person has learned to tolerate a great deal of unhappiness. Among psychiatric patients, the diagnosis most frequently assigned to persons with the 23/32 code type is depressive disorder. Antisocial personality disorder diagnoses are very rare among persons with this code type.

Response to traditional psychotherapy is likely to be poor for the 23/32 persons. They are not introspective; they lack insight into their own behavior; they resist psychological formulations of their problems; and they tolerate a great deal of unhappiness before becoming motivated to change.

2-3 See also point lc in the 2-1-3/2-3-I Triad profile, Figure 14, p. 135.

1. People with the 2-3 combination typically are seen as overcontrolled. They may be unable to start things or to complete them once they are started (Guthrie, 1949). They lack interest and involvement in life (Graham, 1977).
2. They are insecure persons who keep things inside themselves and are unable to express their feelings (Dahlstrom et al., 1972).
 - a. They lack interest or involvement in things and feel constantly fatigued, exhausted, nervous, and inadequate.
 - b. They are frequently described as inadequate and immature.
 - c. Their troubles are typically of long standing.
 - d. Their response to treatment is poor.
3. These two points elevated together indicate ineffective use of repressive and hysteroid defenses (Lachar, 1974).
4. This combination is much more common for women than for men. It indicates a lowered standard of efficiency for prolonged periods of time (Graham, 1977).

5. Gynther, Altman, and Stetten (1973) found that a group of psychiatric inpatients with the 2-3/3-2 pattern, showed depressed mood and decreased activity. A person with the 2-3 pattern also had feelings of helplessness and multiple somatic complaints.

a. Men may complain of lack of recognition on their jobs or of not being promoted when they should be, but they are adequate on their jobs. (Dahlstrom et al., 1972).

b. Women frequently have family or marital maladjustments, but divorce is rare (Dahlstrom et al., 1972).

6. Adolescents in treatment with the 2-3/3-2 pattern (Marks et al., 1974) were referred because of poor relationships with their peers.

They were lonely people with long histories of personal isolation.

They tended to overcontrol their impulses. The Marks, Seeman, and Haller book should be consulted for further information concerning this pattern.

7. Lewandowski and Graham (1972) have found that patients with the 2-3 pattern have significantly less conceptual disorganization, unusual mannerisms and postures, suspiciousness, hallucinatory behavior, and unusual thought content than patients with other patterns.

8. Internal medicine patients have the same symptoms as 1-2/2-1 patients (Guthrie, 1952).

Diagnosis

Psychoneurosis 54%+ Depressive/psychophysiologic

Psychosis 30% Depressive

Brain syndrome 17%+ Chronic

Personality disorder 0%

Personality Description

People who generate this profile are likely to perceive themselves as physically ill. Their complaints are hypochondriacal; that is, they represent the displacement of psychic conflicts in the somatic domain. The personality may be characterized as "hysteroid". A variety of complaints are to be expected, with about 50% of these patients reporting gastrointestinal problems; the musculoskeletal and cardiorespiratory systems are also frequently implicated. Specific symptoms include headache, nausea and vomiting, chest and heart pain, fatigue, weakness, tremor, ulcers, weight loss, paresthesia, loss of interest, impaired sleep, and forgetfulness. Alcoholism is also more frequent among this group than among the total psychiatric population. Such people may derive appreciable secondary gain from their symptoms as well as from the sympathy they demand and often elicit from others. The

duration of their disability is generally longer than a year and previous similar episodes are reported in 50% of the cases.

Adjectives used most often to describe these patients are tense and nervous. People with this profile also typically exhibit depression (manifest sad mood), impaired morale, and multiple neurotic complaints. They tend to be self-depreciating, self-punishing (intropunitive), rather than blame others for their misfortunes. They are vulnerable to threat-sometimes real and sometimes fancied; they are generally fearful and given to constant worrying. These patients have considerable internal conflict over self-assertion and dependency. Psychomotor retardation is evident from the general slow tempo of these people and also from their depressed speech rate which, in turn, reflects a slowing of thought processes. About 70% of the case histories studied report parental indifference or rejection (especially by fathers)— a figure significantly higher than the base rate for the psychiatric population. Sixty per cent of these patients come from disrupted homes; 55% were subjected to a death in their immediate family during childhood. Typically these patients are not the youngest child. It is not surprising, then, that these people report subjective emotional deprivation and lack of parental affection. Their therapists see them as insecure and possessing a basic need for attention.

People with this profile are pessimistic about the benefits of treatment and about the future, perhaps even more so than are people with the 2-7 profile type; scale 2 (Depression) is more elevated for the 2-3-1 (by a half a standard deviation). Treatment outcomes, however, do not indicate that this superpessimistic attitude is justifiable— either in terms of discharge MMPI (obtained at the termination of therapy) or therapists' ratings uncontaminated by the MMPI. With respect to the latter, only 7% were rated "no change" and none were rated "worse." The typical diagnosis for these patients included depression (about 85%); 50% also had psychophysiological concomitants. It would be atypical for people yielding this profile to exhibit such grossly psychotic features as delusional thinking or schizoid 'cognitive slippage/ It is not likely that they would be distrustful of people in general, nor is it likely that they would question the motivation of others. Neither is it probable that psychopathic features would be present; these people tend not to be flippant in word or gesture and do not take the attitude that the world owes them a living.

They also do not undervalue or derogate the opposite sex. Clinical judgments by their therapists suggest that intellectualization is not at all prominent in the armamentarium of defense mechanisms for people with this profile type.

23's

Guthrie described the 23's in the same terms as the 21s above. In the item analyses, however, he found a somewhat different set of items, with the somatic items inoperative in differentiating this group, and with a concentration upon

inefficiency and inadequacy (see the Co23 scale in Appendix I in Volume II). Seemingly, the overcontrol noted above for the normals with high 2's appears in an extreme form in persons in this subgroup. As they describe themselves, they are unable to do things or even to start them. They have difficulty expressing their feelings, are "bottled-up," and feel filled with self-doubts and insecurities. They lack interest or involvement in things and feel constantly fatigued and exhausted, nervous and inadequate much of the time. Marked anxiety or episodes of tension and anxiety are infrequent. Their troubles are typically of long standing. Response to treatment is poor. In behavior, men with 23 codes seem driven, competitive, and industrious, but not wholeheartedly so. They are also dependent and immature, so that the increasing responsibilities that they strive for, and get, are, at the same time, dreaded as sources of additional stress and insecurity. They may suffer because of what they feel is lack of recognition in their jobs, or because they are not promoted as they feel they should be. Despite their conflicts, these men are usually able to maintain an adequate level of efficiency. About half of them failed to return to the internist after being informed that there were no clear-cut physical foundations for their disorders. The women with 23 profiles in Guthrie's group also were termed inadequate and immature. They frequently showed family or marital maladjustment but divorce was rarely reported in the background of these women. Their unhappiness was so chronic and prolonged that it is surprising that alcoholism was not reported more frequently in this group. They showed little pressure to seek help, apparently tolerating unhappiness more than other persons and operating at a lowered level of efficiency for long periods of time.

All these characteristics appear consistent with the description of 23 women furnished by Hathaway and Meehl (1951b). Psychiatric patients with this code show depression prominently and also weakness, apathy, agitation, and tenseness. Diagnostically, these cases are either neurotics of various forms (conversion hysteria being quite rare) or psychotic depressions — manic-depressive, depressed, or involutional. Psychopathic disorders are unlikely to appear in this group. Additional clinical data on the 23 pattern are reported in Marks and Seeman's 231-213 code type (see Chapter 3 for the defining characteristics of this pattern).

Description:

Apathetic depression, anxiety, overcontrol, somatic complaints, passive dependency, shyness, seek but are stressed by responsibility, achievement- and power-oriented, sensitive to rejection, avoidant

Possible Diagnoses:

Female psychosexual dysfunction, Depression, Generalized anxiety dis., Histrionic pers. dis., Panic dis., Affective dis., Bipolar or Cyclothymic dis.

Modifying Scales

- o When Scale 1 is elevated third, the physical symptoms are more pronounced and shift and change over time.
- o Scale 4 coded third suggests hysterical role playing and more overt manipulations to get others' approval. There is a tendency toward impulsive tension-reducing behaviors and addiction proneness.
- o When Scale 6 is elevated, hypersensitivity to criticism and paranoid fear of disapproval is suggested.
- o When Anxiety (ANX) is elevated, tendency to severe anxiety bleeds through the hysterical defenses, with the focus on somatic symptoms as a cause of the anxiety.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Male

Low 0 One interview only, aggressive or belligerent, wants answers or insists on test scores. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, lack of social skills, mother conflict, being nonresponsive or nonverbal, being nonverbal or a nonrelator, being unrealistic or illogical, nervousness, restlessness, unhappiness.

Nothing Low Introverted or self-conscious or socially insecure, lacks skills with the opposite sex, tense, unhappy, worries a great deal, insomnia.

Female

Low 0 Lacks academic drive, marriage oriented, tense on examinations, socially extroverted.

Low 1 Lacks self-confidence, physical inferiority.

Low 4 Lacks self-confidence.

Low 5 Anxieties, nervous, depressed, insomnia, exhaustion, headaches, distractible in study, tense on examinations, indecisive, home conflict, wants answers, socially insecure, socially shy, lacks skills with the opposite sex.

- Note: Scale 3 coded high was infrequently associated with social insecurity.

Low 6 Lacks self-confidence, nonverbal, socially insecure.

- Note: Scale 3 coded high was infrequently associated with social insecurity.

Low 9 Mother conflict.

Nothing Low Mother conflict, father conflict, verbal, tense on examinations, lacks skills with the opposite sex, depressed.

(Drake & Oetting, 1959)

o **Check:** *ANX, DEP, DEP1, DEP2, DEP4, RC2, CYN1* (low), *CYN2* (low), *ASP1* (low), *ASP2* (low), *TPA2* (low), *AGGR* (low), *Dr1, Dr2, Dr3, Dr4, Dr5, Hy3, Hy4, Pd2* (low), *Sc2, Sc3, Sc4, Sc6, Ma4* (low), *R, MAC-R* (low).

TREATMENT

Conflict and confrontation is difficult for individuals with this codetype because of their fears of rejection.

Consequently they tolerate a high degree of both physical and emotional discomfort. They tend not to be psychologically introspective. Catharsis might be frightening because of their fear of loss of emotional control, but it can be quite useful, so progressive relaxation with the introduction of anxiety-loaded topics works best. Therapy should focus on helping them to gradually regain a fuller experience of their emotional life, parts of which they repress as an adaptive response to the emotional overload of loss/trauma. They deny anger towards others and are self-recriminating. Consequently, “going with the resistance” is more effective. The therapist needs to express genuine interest at understanding how they tolerate feeling unappreciated by others without also feeling anger. The therapist could express approval for how the patient continues to see “the best” and how they made “the most” out of a difficult childhood to allow them to feel empathy for themselves, and allow venting of repressed feelings. To achieve catharsis and insight, the therapist should not push the patient to “feel more,” but introduce emotional awareness slowly, with the patient in control of the pace of intensity. Once they feel comfortable that the therapist is not going to push them into being angry with their loved ones, they can develop a more balanced view of their resentments, without feeling that their relationships are threatened. When a particularly painful memory is engaged, they may “shut down” and interrupt their ongoing experience in the therapy session, shifting the focus of attention to something positive. Role-playing a confrontation, “even though you may not feel any of the anger” can be helpful for them to engage the emotions they prefer to avoid. Relief usually follows after they have engaged in a role-play of expressing anger or resentment. Given their childhood histories of early traumatic loss, they are fearful of losing loved ones. Antidepressant medications, cognitive restructuring, thought stopping, and relaxation training can also be useful.

o **Treatment:** Rule out Major Depression and alexithymia. May be resistant to insight and psychological approaches. Nonintrospective. Suggestible. May find it difficult to speak with candor about unpleasant situations, relationships, feelings, and dissatisfactions with treatment. Focused on symptomatic relief. Tolerates support well. Gather recent precipitating events. Look for history of loss or interpersonal conflict. May abuse medications for pain or sleep. See *1-2-3, 2-1-3/2-3-1*.

- Frequent diagnoses: somatoform disorder, frequently among chronic pain patients, affective disorders, high Scale 4 (angry, brooding component to depression, underlying antisocial thoughts, yet their external behavior is usually overcontrolled) with high Scale 6 (depression relates to extreme interpersonal sensitivity, distrust), with high 0 (socially withdrawn, introspective), with high *F* and/or 8 (major depression with psychotic features). (Groth-Marnat, 2009)

Treatment Implications

These individuals will rarely volunteer for psychotherapy, their level of insight is poor, and they usually do not show significant improvement during treatment. This is primarily because their main dynamic is denial and situations such as therapy represent a threat to their avoidant style. Any conflicts are likely to be somatized, and they are highly invested in medical explanations for their complaints. Accordingly, they might seek medical “solutions” to interpersonal conflicts through methods such as tranquilizers and pain medications. A further area that makes treatment difficult is their inability to tolerate a considerable amount of discomfort and seem resigned to live with their unhappiness. However, because their level of distress is usually quite high, some method of symptom relief is indicated, possibly through antidepressant medication. In addition, supportive (rather than insight-oriented) psychotherapy is often beneficial.

Therapy and Therapeutic Pitfalls

Because these clients’ focus is on nonpsychological issues, the initial therapeutic alliance involves focusing on their somatic symptoms to overcome resistance. Many of their physical symptoms could have been precipitated by prolonged stress and tension, leading to actual bodily breakdown. Helping clients maintain a diary of their physical symptoms and how they shift and change in response to stress can help facilitate recognition that their physical symptoms are linked to stress. Because many of these clients have backgrounds that involved emotional deprivation, abandonment, and loss, it is important that they feel supported and nurtured. Direct confrontation tends to lead to clients’ withdrawal. Explore some of their early losses, and help them mourn by engaging empathy for themselves as deprived children. Watch for somatic reactions such as dizzy spells, anxiety, or severe fatigue to interrupt emotive therapy. Observe how physical symptoms occur during the recollection of past painful events to help them learn to self-soothe and relax when overwhelmed emotionally.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Treatment and Self-Help Suggestions

1. Avoid self-destructive habits such as overeating or drinking as a way to self-soothe. With your therapist, develop a list of nurturing and soothing activities as an alternative (e.g., take a walk in a scenic part of town, call a friend, read a favorite book or watch a favorite movie).
2. When you notice any physical symptoms or aches and pains, even though you are trying to be brave, see if you are struggling to hold back any angry or sad feelings. Give yourself permission to examine and confront those feelings by either journaling or talking to someone you trust.
3. Maintain a diary of physical symptoms to see if there is a pattern between your symptoms and anything stressful that might have happened in the same time period.
4. With your therapist, identify significant events in your childhood that involved a loss or a sense of abandonment. In a supportive environment, process feelings that you were unable to safely feel as a child.
5. Allow yourself to talk about your feelings, wants, and desires, being aware of your tendency to shift the focus of attention onto others rather than yourself. While give and take is important in any dialogue, be aware of your tendency to want to give, flatter, and nurture others at your own expense.
6. Resilience building: Identify a particular distressing experience: write about it, and describe the negative emotions and consequences surrounding it. Write without editing or worrying about grammar or spelling. Next, write about the same event, but this time include any positive emotions or consequences involved, even if it feels like “fiction.” As you practice, you may find that the positive emotions become easier to imagine and identify.¹

¹ A study of adaptive cognitive change surrounding an upsetting event showed that the written expression of positive feelings is as, if not more, therapeutic than writing about negative emotions (Segal, Tucker, & Coolidge, 2009).
(Levak, Siegel, Nichols, & Stolberg, 2011)

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you are a very dutiful, responsible individual who generally likes to please others and avoid conflict. You tend to go the extra mile to see other peoples' perspectives and you're not afraid to sacrifice yourself for others. Sometimes people can take advantage of you because of your willingness to help and your difficulty setting limits with them. You expect that people will notice how much you give them and will be grateful, but when they are not, it deeply hurts you. From an early age you may have had to be the dutiful and responsible child, perhaps because of an early death or loss in your family, or an emotionally unavailable parent. You learned

from an early age to be brave, to be a “good soldier,” and not to bother the adults in your life who you felt had already suffered enough. You continue to go through life sacrificing yourself for others and finding it difficult to confront people. This may lead to stress, which can then manifest in physical symptoms such as headaches, nausea, anxiety, and exhaustion. Your therapist may want to give you some medicine to help you with some of your symptoms of depression. That may surprise you since you may have become so accustomed to feeling unhappy that you do not see yourself as depressed. Even though you smile and stay positive, you may experience some underlying depressive symptoms, including difficulties with sleep, feeling fatigued, having low energy, low sex drive, and diminished appetite. Having difficulties with concentration and memory can also be symptoms of depression. Work with your therapist on developing some empathy for yourself as a brave child who tried to take on responsibility in the face of loss. Learn how to express anger directly so that you can set limits with others without feeling that you are rejecting them. Your therapist may want you to try some medication so you can feel better.

Feedback Statements—Elevated Profiles (T-Score > 65)

Physical Complaints

People with your profile often have various physical complaints, including gastrointestinal problems, musculoskeletal problems, cardiovascular problems, headaches, nausea, vomiting, chest pain, fatigue, weakness, neurological symptoms, or weight loss.

Memory and Concentration Problems

When people are depressed, they often have difficulty with concentration and memory. You may find yourself losing track of things and unable to remember what you did earlier in the day; you may even fear that you are somehow losing your mind. These symptoms will usually disappear once the depression is treated.

Depression, Sad Mood, Worried

People with your profile often spend a lot of time thinking about sad and even morbid things. You probably find yourself worrying that there’s something wrong with you, and you may live with a sense of dread and anxiety as if something terrible is about to happen.

Self-Deprecating or Self-Punishing

People with this profile tend to be their own worst critics. You probably feel like a failure even if, to others, you have accomplished much. It’s easy for you to see yourself as inadequate or to feel like a failure and to feel guilty when you hear about others’ successes, as if it highlights your own failure. People with your profile are quick to punish and

blame themselves for anything that goes wrong. Whenever you get into conflict with someone you love, it's easy for you to feel like you did something wrong and to worry that you're going to be rejected and abandoned.

Guilty

You often feel a sense of guilt, as if you have done something wrong and are going to be punished. You may feel guilty that you have not done enough for others.

Brave in the Face of Pain

People with your profile are often attempting to be brave, to smile through difficulties, and to prevent others from seeing how sad they feel. Sometimes your profile has been called the "smiling depression" because you work so hard to be brave in the face of pain. It's important for you to be seen as cheerful and positive no matter how bad you feel.

Responsible, Conscientious, Self-Sacrificing

People with this profile are often described as extremely responsible and conscientious. You feel a sense of duty and responsibility to get things done and to be productive. It's as if you're always trying to be "good," to do the right thing, and to please people around you. It's hard for you not to take on responsibilities, even when others have not asked you to do so. People with your profile can come across as self-sacrificing. However, sacrificing yourself for others may lead you to develop resentments and may lead other people to resent you for not taking better care of yourself.

Lifestyle and Background Feedback

People with your profile grew up in difficult circumstances with early losses such as parental indifference, rejection, or otherwise disrupted homes. Perhaps you lost a parent and from an early age had to be brave, smiling in the face of pain. One way of dealing with these early losses was to try to stay positive and to please others to avoid further losses. Physical symptoms would reflect the stress you put on your body by pleasing others and avoiding conflict. You may use chemical agents as a way of feeling better.

Normal-Range Feedback (T-Score 50 to 65)

Your profile is in the normal range and suggests that you tend to sacrifice your wants and desires for the benefit of others. Being assertive and standing up for yourself can be difficult, and face-to-face confrontations can be quite frightening. You may develop headaches, upset stomach, or other physical symptoms when placed in difficult

emotional situations. Interactions that involve feelings of sadness or anger are particularly difficult and likely to trigger these symptoms.

(Levak, Siegel, Nichols, & Stolberg, 2011)

231/213 Codes

o Somatization in the context of anxiety, insecurity, depression, and helplessness, with inhibition. See *1-2-3, 2-3/3-2*.

Rules

2, 3, and 1 above 70 Ts

2 minus 1 more than 5 T-scores

2 minus 3 more than 5 T-scores

7 and less than 2, 3, and 1

7 greater than 8 (or 8 minus 7 less than 5 T-scores) 9 and below 70 Ts

0 greater than 9

L, F, and K below 70 Ts

Most Descriptive

105. Manifests hypochondriacal tendencies (9.0) ++

7. Psychic conflicts are represented in somatic symptoms (8.8) +

9. Presents self as being physically, organically sick (8.4) ++

93. Exhibits depression (manifest sad mood) (8.2) +

102. Genotype has hysteroid features (8.2) ++

1. Is vulnerable to real or fancied threat; generally fearful; is a worrier (8.0) +

20. Complains of difficulty in going to sleep (7.8)

82. Gets appreciable "secondary gain" from symptoms (7.6) +

2. Demands sympathy from others (7.4) +

21. Has multiple neurotic manifestations (7.4) +

60. Has inner conflicts about self-assertion (7.2) +

5. Possesses a basic insecurity and need for attention (7.0)

26. Reacts to frustration intropunitively (i.e., punishes self) (7.0)

56. Complains of weakness or easy fatigability (7.0)

- 65. Has an exaggerated need for affection (7.0)
- 66. Is a serious person who tends to anticipate problems and difficulties (7.0) +
- 75. Has inner conflict about emotional dependency (7.0)

Least Descriptive

- 42. Is "normal," healthy, symptom free (1.0) —
- 104. Delusional thinking is present (1.8) —
- 106. Has grandiose ideas (extreme is delusions of grandeur) (1.8) —
- 11. Is cheerful (2.0)
- 39. Genotype has psychopathic features (2.0)
- 40. Genotype has schizoid features (2.0) —
- 96. Genotype has paranoid features (2.0) —
- 107. Would be organized and adaptive when under stress or trauma (2.2)
- 36. Has a rapid personal tempo; thinks, talks, moves at a fast rate (2.4) —
- 37. Defenses are fairly adequate in relieving psychological distress (2.6)
- 43. Undervalues and consistently derogates the opposite sex (2.6) —
- 44. Is distrustful of people in general; questions their motivations (2.6)-
- 61. Tends to be flippant both in word and gesture (2.6)
- 41. Has good verbal-cognitive insight into own personality structure and dynamics (3.0)
- 45. Thinks and associates in unusual ways; has unconventional thought processes (3.0)
- 63. Has a resilient ego-defense system; has a safe margin of integration (3.0) +
- 72. Is demanding; tends to take the attitude "the world owes me a living" (3.0)
- 76. Avoids situations where own performance will be inferior to that of others (3.0)
- 95. Accepts others as they are; is not judgmental (3.0)
- 101. Utilizes intellectualization as a defense mechanism (3.0)

Diagnosis

Psychoneurosis 54%+	Depressive/psychophysiologic
Psychosis 30%	Depressive
Brain syndrome 17%+	Chronic
Personality disorder 0%	

Personality Description

People who generate this profile are likely to perceive themselves as physically ill. Their complaints are hypochondriacal; that is, they represent the displacement of psychic conflicts in the somatic domain. The personality may be characterized as “hysteroid”. A variety of complaints are to be expected, with about 50% of these patients reporting gastrointestinal problems; the musculoskeletal and cardiorespiratory systems are also frequently implicated. Specific symptoms include headache, nausea and vomiting, chest and heart pain, fatigue, weakness, tremor, ulcers, weight loss, paresthesia, loss of interest, impaired sleep, and forgetfulness. Alcoholism is also more frequent among this group than among the total psychiatric population. Such people may derive appreciable secondary gain from their symptoms as well as from the sympathy they demand and often elicit from others. The duration of their disability is generally longer than a year and previous similar episodes are reported in 50% of the cases.

Adjectives used most often to describe these patients are tense and nervous.

People with this profile also typically exhibit depression (manifest sad mood), impaired morale, and multiple neurotic complaints. They tend to be self-deprecating, self-punishing (intropunitive), rather than blame others for their misfortunes. They are vulnerable to threat-sometimes real and sometimes fancied; they are generally fearful and given to constant worrying. These patients have considerable internal conflict over self-assertion and dependency. Psychomotor retardation is evident from the general slow tempo of these people and also from their depressed speech rate which, in turn, reflects a slowing of thought processes. About 70% of the case histories studied report parental indifference or rejection (especially by fathers)— a figure significantly higher than the base rate for the psychiatric population. Sixty per cent of these patients come from disrupted homes; 55% were subjected to a death in their immediate family during childhood. Typically these patients are not the youngest child. It is not surprising, then, that these people report subjective emotional deprivation and lack of parental affection. Their therapists see them as insecure and possessing a basic need for attention.

People with this profile are pessimistic about the benefits of treatment and about the future, perhaps even more so than are people with the 2-7 profile type; scale 2 (Depression) is more elevated for the 2-3-1 (by a half a standard

deviation). Treatment outcomes, however, do not indicate that this superpessimistic attitude is justifiable— either in terms of discharge MMPI (obtained at the termination of therapy) or therapists' ratings uncontaminated by the MMPI. With respect to the latter, only 7% were rated "no change" and none were rated "worse." The typical diagnosis for these patients included depression (about 85%); 50% also had psychophysiological concomitants. It would be atypical for people yielding this profile to exhibit such grossly psychotic features as delusional thinking or schizoid 'cognitive slippage/ It is not likely that they would be distrustful of people in general, nor is it likely that they would question the motivation of others. Neither is it probable that psychopathic features would be present; these people tend not to be flippant in word or gesture and do not take the attitude that the world owes them a living. They also do not undervalue or derogate the opposite sex. Clinical judgments by their therapists suggest that intellectualization is not at all prominent in the armamentarium of defense mechanisms for people with this profile type.

See point 1.a. in the 2-1-3/2-3-1 Triad profile, Figure 14, p. 135.

- o People with this pattern tend to be smiling depressives. They smile while they cry, and they do not know why. They deny aggression and hostility, and usually are inhibited. This profile is frequent for people with deteriorating neurological diseases (Caldwell, 1972). Fifty percent of the people with this pattern in one population had lost their parents when they were young (Caldwell, 1985).
- o People usually have at least moderate distress and multiple somatic complaints. They tend to have learned to tolerate the unhappiness and therefore may have poor motivation for treatment (Lachar, 1974).
- o Marks, Seeman, and Haller (1974) found this 2-3-1/2-1-3 pattern in a university hospital and outpatient clinic. People with this pattern tended to show a combination of depression and somatic complaints. They saw themselves as physically sick. The Marks, Seeman, and Haller book should be consulted for further information concerning this profile.

2317

- o In this pattern, the 7 scale is also elevated above 70, but is not necessarily the next highest scale. People with this pattern tend to be older than patients in general. They feel they cannot get things

done and are pessimistic. Their somatic complaints are secondary to their depression (Caldwell, 1972).

234/324 Codes

Dysphoric or depressed. Also immature and dependent. See 2-3/3-2, 3-4/4-3

Male

Low 0 Father conflict, one interview only, aggressive or belligerent, wants answers or insists on test scores. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, lack of social skills, mother conflict, being nonresponsive or nonverbal, being nonverbal or a nonrelator, being unrealistic or illogical, nervousness, restlessness, unhappiness.

Nothing Low Introverted or self-conscious or socially insecure, lacks skills with the opposite sex, tense, unhappy, worries a great deal, insomnia.

- Note: Scale 4 coded high was infrequently associated with lack of skills with the opposite sex.

Female

Low 0 Father conflict, home conflict, lacks academic drive, marriage oriented, tense on examinations, depressed, anxieties, indecisive, lacks skills with the opposite sex, socially extroverted.

- Note: Scale coded low was infrequently associated with home conflict, depression, lack of skills with the opposite sex.

Low 1 Father conflict, home conflict, lacks academic drive, depressed, anxieties, indecisive, lacks self-confidence, physical inferiority, lacks skills with the opposite sex, socially extroverted.

Low 5 Father conflict, home conflict, mother conflict, rebellious toward home, lacks academic drive, tense on examinations, distractible in study, depressed, anxieties, nervous, exhaustion, insomnia, headaches, indecisive, lacks skills with the opposite sex, socially insecure, socially shy, wants answers.

- Note: Scale 4 coded high was infrequently associated with social insecurity.

Low 6 Father conflict, home conflict, lacks academic drive, vague goals, depressed, anxieties, indecisive, lacks self-confidence, lacks skills with the opposite sex, socially insecure, nonverbal.

- Note: Scale 4 coded high was infrequently associated with social insecurity.

Low 7/8 Father conflict, home conflict, lacks academic drive, depressed, anxieties, indecisive, lacks skills with the opposite sex.

Low 9 Father conflict, home conflict, mother conflict, lacks academic drive, depressed, anxieties, indecisive, lacks skills with the opposite sex.

Nothing Low Father conflict, home conflict, mother conflict, lacks academic drive, tense on examinations, depressed, anxieties, indecisive, lacks skills with the opposite sex, verbal.
(Drake & Oetting, 1959)

235 Code

Male

Low 0 Home dependency, wants reassurance only, one interview only (3-0), four or more conferences (35), worries a great deal, aggressive or belligerent, wants answers or insists on test scores.

- Note: Scale coded low was infrequently associated with worrying a great deal; Scale 5 coded high was infrequently associated with wanting answers or insisting on test scores. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, lack of social skills, lack of skills with the opposite sex, mother conflict, being nonresponsive or nonverbal, being nonverbal or a nonrelator, being unrealistic or illogical, nervousness, restlessness, tension, unhappiness.

Low 1 Home dependency, four or more conferences, wants reassurance only, restless, worries a great deal.

- Note: Scale 3 coded high was infrequently associated with restlessness.

Low 4/6/7/8/9 Home dependency, four or more conferences, wants reassurance only, worries a great deal.

Nothing Low Introverted or self-conscious or socially insecure, lacks skills with the opposite sex, home conflict, home dependency, four or more conferences, wants reassurance only, tense, imhappy, worries a great deal, insomnia.

- Note: Scale 5 coded high was infrequently associated with tension.

Female

Low 0 Lacks academic drive, tense on examinations, marriage oriented, socially extroverted.

Low 1 Socially shy, lacks self-confidence, physical inferiority.

- Note: Scale 5 coded high was infrequently associated with social shyness.

Low 4 Lacks self-confidence.

Low 6 Lacks self-confidence, socially insecure, nonverbal.

- Note: Scale 3 coded high was infrequently associated with social insecurity.

Low 9 Mother conflict.

Nothing Low Mother conflict, father conflict, depressed, tense on examinations, distractible in study, verbal, lacks skills with the opposite sex.

- Note: Scale 5 coded high was infrequently associated with father conflict.

(Drake & Oetting, 1959)

236 Code

Male

Low 0 One interview only, aggressive or belligerent, wants answers or insists on test scores. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, lack of social skills, mother conflict, being nonresponsive or nonverbal, being nonverbal or a nonrelator, being unrealistic or illogical, nervousness, restlessness, unhappiness.

Nothing Low Introverted or self-conscious or socially insecure, lacks skills with the opposite sex, tense, unhappy, worries a great deal, insomnia

Female

Low 0 Anxieties, resistant in the interview, 8+ conferences, tense on examinations, marriage oriented, lacks academic drive, socially extroverted.

Low 1 Anxieties, 8+ conferences, lacks self-confidence, physical inferiority.

Low 4 Anxieties, 8+ conferences, lacks self-confidence, shy in the interview.

Low 5 Anxieties, depressed, nervous, exhaustion, insomnia, headaches, 8 + conferences, wants answers, nonresponsive, physical inferiority, indecisive, home conflict, tense on examinations, distractible in study, socially shy, lacks skills with the opposite sex, socially insecure.

Note: Scale 3 coded high was infrequently associated with nonresponsiveness.

Low 7/8 Anxieties, 8+ conferences.

Low 9 Anxieties, 8+ conferences, mother conflict.

Nothing Low Anxieties, depressed, restless, 8+ conferences, verbal, mother conflict, father conflict, tense on examinations, lacks skills with the opposite sex.

(Drake & Oetting, 1959)

237/273/327/372/723/732 Codes

- o Like 2-7/7-2 but more dependent, helpless, and appealing, and lacking in insight. Somewhat less anxious and depressed with reduced suicide risk. More conforming, conventional, and trusting. May be docile, with clinging dependency. See 2-3/3-2, 2-7/7-2, 3-7/7-3.

Male

Low 0 One interview only, tense, tense on examinations, indecisive, unhappy (27), worries a great deal, lacks knowledge or information, aggressive or belligerent, wants answers or insists on test scores.

- Note: Scale coded low was infrequently associated with indecisiveness, unhappiness, worrying a great deal. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, lack of social skills, mother conflict, being nonresponsive or nonverbal, being nonverbal or a nonrelator, being unrealistic or illogical, nervousness, restlessness, unhappiness (3-0).

Low 1 Home conflict, nonresponsive or nonverbal, tense, tense on examinations, indecisive, unhappy, worries a great deal, confused.

Low 4/5/6/8 Tense, tense on examinations, indecisive, unhappy, worries a great deal.

Low 9 Generally dependent, tense, tense on examinations, indecisive, unhappy, worries a great deal.

Nothing Low Introverted or self-conscious or socially insecure, lacks social skills, lacks skills with the opposite sex, home conflict, mother conflict, sibling conflict, nonresponsive or nonverbal, tense, tense on examinations, indecisive, unhappy, worries a great deal, insomnia, confused.

- Note: Scale 3 coded high was infrequently associated with mother conflict.

Female

Low 0 Anxieties, depressed, insomnia, lacks self-confidence, distractible in study, tense on examinations, marriage oriented, lacks academic drive, socially shy (27), socially insecure (27), socially extroverted (3-0), 4 to 7 conferences.

- Note: Scale coded low was infrequently associated with depression, lack of self-confidence, social shyness, social insecurity; Scale 3 coded high was infrequently associated with social insecurity.

Low 1 Anxieties, depressed, insomnia, lacks self-confidence, physical inferiority, distractible in study, socially shy, socially insecure, 4 to 7 conferences.

- Note: Scale 3 coded high was infrequently associated with social insecurity.

Low 4 Anxieties, depressed, insomnia, lacks self-confidence, distractible in study, socially shy, socially insecure, 4 to 7 conferences.

- Note: Scale 3 coded high was infrequently associated with social insecurity.

Low 5 Anxieties, depressed, insomnia, nervous, headaches, exhaustion, lacks self-confidence, indecisive, distractible in study, tense on examinations, socially shy, socially insecure, lacks skills with the opposite sex, 4 to 7 conferences, wants answers, home conflict.

- Note: Scale 3 coded high was infrequently associated with social insecurity.

Low 6/8 Anxieties, depressed, insomnia, lacks self-confidence, distractible in study, socially shy, socially insecure, 4 to 7 conferences.

- Note: Scale 3 coded high was infrequently associated with social insecurity.

Low 9 Anxieties, depressed, insomnia, lacks self-confidence, distractible in study, socially shy, socially insecure, 4 to 7 conferences, mother conflict.

- Note: Scale 3 coded high was infrequently associated with social insecurity.

Nothing Low Anxieties, depressed, insomnia, headaches, lacks self-confidence, distractible in study, tense on examinations, socially shy, socially insecure, lacks skills with the opposite sex, 4 to 7 conferences, verbal, mother conflict, father conflict, sibling conflict.

- Note: Scale 3 coded high was infrequently associated with social insecurity.

(Drake & Oetting, 1959)

Description:

High aspirations and standards, passive-aggressive, dependent

Possible Diagnoses:

Phobic disorders and sexual dysfunctions

238 Code

Male

Low 0 Introverted or self-conscious or socially insecure (28), lacks skills with the opposite sex, lacks knowledge or information, aggressive or belligerent, wants answers or insists on test scores, one interview only.

- Note: Scale coded low was infrequently associated with lack of skills with the opposite sex. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, lack of social skills, mother conflict, being nonresponsive or nonverbal, being nonverbal or a nonrelator, being unrealistic or illogical, nervousness, restlessness, unhappiness.

Low 1/4/5/6/7 Introverted or self-conscious or socially insecure, lacks skills with the opposite sex, lacks knowledge or information.

Low 9 Introverted or self-conscious or socially insecure, lacks skills with the opposite sex, lacks knowledge or information.

Nothing Low Introverted or self-conscious or socially insecure, lacks skills with the opposite sex, tense, indecisive, unhappy, worries a great deal, insomnia, lacks knowledge or information, confused.

Female

Low 0 Anxieties, depressed, verbal, distractible in study, tense on examinations, lacks academic motivation, marriage oriented, lacks skills with the opposite sex, socially extroverted.

- Note: Scale 0 coded low was infrequently associated with depression and lack of skills with the opposite sex.

Low 1 Anxieties, depressed, verbal, distractible in study, lacks skills with the opposite sex, lacks self-confidence, physical inferiority.

Low 4 Anxieties, depressed, verbal, distractible in study, lacks skills with the opposite sex, lacks self-confidence.

Low 5 Anxieties, depressed, nervous, headaches, insomnia, exhaustion, verbal, wants answers, distractible in study, tense on examinations, lacks skills with the opposite sex, socially shy, socially insecure, indecisive, family conflict.

Low 6 Anxieties, depressed, verbal (38), nonverbal (2-6), distractible in study, lacks skills with the opposite sex, socially insecure, lacks self-confidence.

Low 7 Anxieties, depressed, verbal, distractible in study, lacks skills with the opposite sex.

Low 9 Anxieties, depressed, verbal, distractible in study, lacks skills with the opposite sex, mother conflict.

Nothing Low Anxieties, depressed, verbal, 8+ conferences, distractible in study, tense on examinations, lacks skills with the opposite sex, mother conflict, father conflict, sibling conflict.

(Drake & Oetting, 1959)

239 Code

Male

Lopw 0 One interview only, tense on examinations, aggressive or belligerent, wants answers or insists on test scores, rationalizes a great deal. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, shyness in the interview, lack of social skills, mother conflict, being nonresponsive or nonverbal, being nonverbal or a nonrelator, being unrealistic or illogical, nervousness, restlessness, indecisiveness, unhappiness.

Low 1/4/5/6/7/8 Tense on examinations, aggressive or belligerent, rationalizes a great deal.

Nothing Low Introverted or self-conscious or socially insecure, lacks skills with the opposite sex, tense on examinations, tense, unhappy, worries a great deal, insomnia, aggressive or belligerent, rationalizes a great deal.

- Note: Scale 9 coded high was infrequently associated with worrying a great deal and lack of skills with the opposite sex

Female

Low 0 Lacks self-confidence, marriage oriented, tense on examinations, lacks academic drive, socially insecure (29), socially extroverted (39, 39-0, 3-0, 9-0), verbal.

- Note: Scale coded low was infrequently associated with lack of self-confidence and social insecurity; Scale 3 coded high was infrequently associated with social insecurity.

Low 1 Lacks self-confidence, physical inferiority, marriage oriented, vague goals, socially insecure (29), socially extroverted (39, 9-1).

- Note: Scale 3 coded high was infrequently associated with social insecurity.

Low 4 Lacks self-confidence, marriage oriented, socially insecure (29), socially extroverted (39), shy in the interview, nonresponsive.

- Note: Scale 3 coded high was infrequently associated with nonresponsiveness and social insecurity.

Low 5 Lacks self-confidence, indecisive, marriage oriented, tense on examinations, distractible in study, socially insecure (29, 2-5), socially extroverted (39), socially shy (2-5), lacks skills with the opposite sex, depressed, nervous, anxieties, headaches, insomnia, exhaustion^ wants answers, verbal, home conflict.

- Note: Scale 3 coded high was infrequently associated with social insecurity.

Low 6 Lacks self-confidence, marriage oriented, socially insecure (29, 2-6), socially extroverted (39), nonverbal.

- Note: Scale 3 coded high was infrequently associated with social insecurity.

Low 7/8 Lacks self-confidence, marriage oriented, socially insecure (29), socially extroverted (39).

- Note: Scale 3 coded high was infrequently associated with social insecurity.

Nothing Low Lacks self-confidence, marriage oriented, tense on examinations, socially insecure (29), socially extroverted (39), lacks skills with the opposite sex, depressed, verbal, father conflict, mother conflict.

- Note: Scale 3 coded high was infrequently associated with social insecurity.

(Drake & Oetting, 1959)

Code-Type 2-4/4-2

Descriptors

Complaints

Depressed, dysphoric, trapped, anxious, alienated, relationship (family or work) problems, feeling victimized, possible legal problems, feeling overwhelmed, dissatisfied

Thoughts

Defeated, negative, resentful, blaming, insecure, self-defeating, anxious, insecure, frustrated, self- and other-blaming, pessimistic

Emotions

Angry, sad, trapped, guilty, sometimes intropunitive and sometimes extropunitive, passive-dependent

Traits and Behaviors

Impulsive, acting out, addictive personality, passive-aggressive, manipulative, demanding, hostile, sarcastic, argumentative

(Levak, Siegel, Nichols, & Stolberg, 2011)

Therapist's Notes

In the average to moderate range, the 2-4 individual feels trapped and defeated, conflicted between self- and other-blame. They are apprehensive about relying on others emotionally. The elevated 2-4 code type may reflect a personality disorder with resentment, anger, depression, and self-defeating behavior. In some cases, the 2-4 code type reflects a high Scale 4 individual who has recently experienced a loss or setback, resulting in a depressed profile. These clients are narcissistic, dependent, self-serving, manipulative, and alienated.

When depressed, such individuals become angry, dissatisfied, and frustrated with the world, externalizing blame. At times their anger is self-directed, and they become self-defeating and self-destructive. They are quick to give up when stressed. At other times, their anger is externalized, and they can lash out and be vindictive, blaming others for

their own misfortunes. These individuals feel self-pity and want to be rescued, but they distrust others' motives, reflecting the basic mistrust of the high Scale 4. In the presence of a history of antisocial or narcissistic and self-indulgent behavior, the 2-4 may reflect a situational depression subsequent to behavior that is impulsive or poorly planned. The depression is characterized by an exaggerated, angry remorse, without significant behavior change. Self-anger around their impulsive behavior serves as a rationalization for their inability to move forward and to make positive behavioral changes.

Not all 2-4 profiles reflect a chronic personality disorder. This code type can occur in situational depressions where individuals feel trapped, bitter, and unable to see positive future options. A lifestyle of stable relationships and perseverance toward tangible goals would suggest a situational depression with temporary feelings of angry hopelessness. 2-4 code types express low self-esteem in an angry, self-destructive way. They avoid responsibility, but with exaggerated self-blaming statements. Clients with this profile are quite argumentative and critical. They are also passively dependent and passive-aggressive. Their depression is manifested as negativity rather than as communicative sadness.

If Scale 3 is elevated third, the anger, resentment, and bitterness associated with the 2-4 is muted by hysterical defenses. Individuals with a 2-4-3 code type will exhibit more hysterical role playing and a tendency to fit in to other people's expectations but will act out in subtle, passive-aggressive ways. Individuals with this profile may play the right role and appear acquiescing and compliant but then may exhibit quick-temper outbursts and episodic acting out followed by denial. They tend to lack insight, and their behaviors reflect the conflict between the expression of anger and resentment on one hand and needs to be accepted and loved on the other. Those with a 2-4-3 oscillate between defeated despair and cheerful role playing.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Lifestyle and Family Background

If these clients have exhibited a history of antisocial or narcissistic self-indulgent behavior but have recently experienced a setback or loss, then the 2-4 code type reflects a situational depression in character-disordered individuals. These individuals are vulnerable to suicide attempts and other self-destructive acts. In the presence of a history of dysthymia, depression, anxiety, but also anger and self-defeating behavior, the profile may reflect a self-defeating personality style. The presence of a recent setback or loss and the absence of a history of self-destructive behavior will help define whether this is the result of a lifelong pattern of acting out, self-indulgent, and self-defeating behavior or recent anger and bitter depression due to feeling trapped. The anger and the sense of defeat make the depression difficult to treat. In either case, look for backgrounds of unavailable, abusive, or self-indulgent parents. Typically, 2-4 individuals don't trust authority figures because of unavailable or inconsistent parenting. Our

hypothesis is that this profile reflects an adaptive response to emotional abandonment or lack of reliable emotional support. In response, the 2-4 becomes emotionally numb, inhibiting the normal operation of vulnerable and engaging feelings. These individuals alternate between periods of emotional numbness and intense, angry, negative sadness. During these periods of sadness, 2-4 individuals will engage in self-defeating and self-destructive behaviors. (Levak, Siegel, Nichols, & Stolberg, 2011)

This codetype may reflect either a chronic 24/42 lifestyle or a high Scale 4 individual who recently has experienced a situational setback and is feeling trapped, angry, and defeated. In either case, the 24 individual is feeling depressed, frustrated, dissatisfied, resentful, and pessimistic about the future. Others may see them as critical, argumentative, restless, and negative. A 24 individual can be self-defeating, often acting out impulsively when stress builds, and then feeling defeated and distressed with the consequences. They oscillate between self-blame and blaming others. Anger is episodically turned either inward, whereupon they are vulnerable to self-destructive or self-defeating behavior or, sometimes, outward and blaming, feeling that their situation can't change without others changing first. They often report feeling the unfortunate victim of circumstance, avoiding responsibility for their difficulties. For individuals with a high Scale 4 history of acting out, but currently dealing with the adverse consequences of their behavior, the 24/42 profile reflects someone who has had difficulty maintaining control over their impulses and is therefore experiencing situational and transient depression and remorse. After acting out and getting caught, they feel distress. However, this distress is the result of being caught and punished, rather than impulse-restraining guilt. Although their apparent conscience pangs may be severe, even out of proportion to the event, their acting-out behaviors are likely to recur in the future in a cyclic fashion. Home and family problems, employment difficulties, and histories of interpersonal problems are typical for the 24/42 codetype. They are resentful of any demands placed on them. Substance abuse or alcoholism is common. In some cases, legal difficulties may also be present. Some of these individuals can manifest interpersonal relationship problems and career instabilities without any legal difficulties. For most 24 individuals, a passive-dependent adjustment pattern is predominant. They seek out relationships where someone "saves them" from the results of their impulsive behavior, gravitating towards co-dependent caretakers. After age 40, the life of poor judgment and consequent failure to achieve satisfaction can result in a deeply entrenched pattern of self-blame, depression, and self-anger, with occasional self-destructive and suicidal behavior. Suicide evaluation is important, since they may act out self-destructively, both out of a sense of defeat and as an angry response to punish others. Scale 7, 3, or 8 is often the third highest. Adolescents with the 24 codetype are resentful of authority, argumentative, selfdefeating, and lack drive. They often use chemical agents as way of medicating their dysphoria. The 24 adolescent is the "nothing to lose" teenager who feels trapped in their current predicament and may take impulsive action, such as running away, as a way of escaping a difficult situation. Adolescents with this codetype feel alienated from their family members and want to get away. They perceive their

caregivers as lacking in affection and unreliable. School difficulties, with truancy and poor grades, are typical.

Teenage unmarried mothers may obtain this profile, though it may be reflecting the trapped depression associated with being a caretaker with limited resources.

Definition: The specific characteristics of the *24/42* code vary markedly with the third highest scale. See especially *246, 247, 248, 249*, and combinations.

- o Depressed mood, anhedonia, anxiety, tension, frustration, irritability, impulsiveness, anger, and often exaggerated guilt and self-reproach. May be critical, argumentative, and resentful. Both intro- and extro-punitive. Chronically poor response to stress. Depression is often externalized and situational. Interpersonally difficult, with irresponsibility, dependency conflicts, belligerence, argumentativeness, manipulations, and resentment. Look for a long-term pattern of irresponsibility and self-defeating conduct; family alienation; chronic marital discord; and a history of childhood deprivation, delinquency, authority conflicts, substance abuse, arrests, and job losses.
- o Often in difficulty with law; impulsive and unable to delay gratification of impulses; little respect for social standards and values; acts---out; excessive drinking likely
- o Frustrated by lack of own accomplishments; resentful of demands placed by others; following acting---out may express guilt and remorse but is not sincere; suicidal ideation and attempts possible (especially if both scales are grossly elevated)
- o Energetic, sociable, outgoing; creates favorable first impression; tendencies to manipulate others; causes resentment in long---term relationships; beneath façade of competent, comfortable person is self---conscious, self- -dissatisfied, passive--- dependent person; may express need for help and desire to change, but prognosis for psychotherapy is poor; likely to terminate therapy prematurely when stress subsides or when extracted from legal difficulties

This high point pair is characteristic of two different types of clients. The most common is psychopathic individuals who have been caught in some illicit or illegal behavior and are subsequently being evaluated. The depression is a reaction to the constraints being placed on their behavior, such as being put in a prison or a hospital. This depression abates when escape from stress is effected or when the constraints are removed. Nevertheless, the presence of even this situational depression results in a slightly better prognosis than for individuals in similar

circumstances who do not admit this affect. The most valid interpretation for these psychopathic clients would use primarily the correlates of Scale 4.

Other clients obtaining this high point pair are described as being extremely hostile, angry, and resentful.

Marital and/or family turmoil is prevalent, resulting in intense dissatisfaction with their present life situation. Clients with this high point pair are immature, dependent, egocentric, and often vacillate between pitying themselves and blaming others for their difficulties. Impulse control problems are quite prevalent, as they exhibit an apparent inability to plan ahead if not a reckless disregard of the consequences of their behaviors. They may react to stress with excessive alcohol consumption and/or drug abuse. They experience a failure to appreciate the interpersonal side of life, have difficulty showing warmth, tend to resent authority figures and demands imposed on them, and may misinterpret the meaning of social events and relationships. Psychotherapeutic intervention will prove difficult, as numerous characterological difficulties exist, and the depressive features are chronic in nature and deeply ingrained into the character structure.

Symptoms and Behaviors

The most significant aspect of the 24/42 code is the underlying antisocial trend to the clients' personalities, with difficulty maintaining control over their impulses. However, when they act on their underlying antisocial impulses, they experience guilt and anxiety regarding the consequences of their actions. This anxiety usually occurs too late to serve as an effective deterrent, and these individuals are unable to plan ahead effectively. The depression they experience is probably situational, and the distress they feel may reflect a fear of external consequences rather than an actual internalized moral code. When the situation has subsided, there is usually further acting out. For this reason, the 24/42 code is sometimes considered to reflect an antisocial personality who has been caught.

The history of persons with high Scales 2 and 4 is often characterized by heavy drinking and/or drug abuse, which serves as a form of self-medication for their depression (check the MAC-R, ACK/Alcohol Acknowledgment, and APS/Alcohol Potential scales). Their interpersonal relationships are poor, which is reflected in numerous family difficulties (check the FAM/Family Problems scale) and sporadic employment. Their prospects for long-term employment are rarely favorable (check the WRK/Work Interference scale). These problems have often resulted in numerous legal complications (check the ASP/Antisocial Practices scale).

The hostility that is present with the 24/42 code may be expressed either directly or indirectly. A more direct expression is suggested if Scale 6 is high, as these individuals may feel justified in externalizing their anger because of real or imagined wrongs that have been committed against them. In contrast, a low 6 may reflect a suppression or unconscious denial of hostility. If high energy levels are suggested by a high Scale 9, the person may be extremely dangerous and volatile, and may have committed violent behaviors.

The 24/42 code is associated with personality disorders, especially passive-aggressive or antisocial personalities. This is further strengthened if Scale 6 is also high. However, this code frequently reflects an adjustment disorder with a depressed mood. An important distinction to make is whether the depression is reactive or chronic. If chronic, difficulties related to anxiety, conversions, and depression (neurotic features) will more likely be predominant, especially if Scales 1 and 3 are also high. A reactive depression is more likely to represent an antisocial personality who has been apprehended for his or her impulsive acting out. Substance abuse may be either the primary difficulty or may occur in addition to the other disorders suggested earlier. If Scale 4 is extremely elevated (above 90), a psychotic or prepsychotic process may be present, especially if *F* and 8 are also high.

Personality and Interpersonal Characteristics

The initial impression may be friendliness or even charm, and, in a hospital setting, these patients may attempt to manipulate the staff. At their best, they can appear sociable, competent, and enthusiastic. Others might perceive them as sociable and outgoing. However, in the long term, they are likely to produce resentment in interpersonal relationships. While appearing superficially competent and confident, they are likely to experience an underlying sense of dissatisfaction and feel self-conscious. Such persons respond to their failures with pessimism, self-criticism, and self-doubt. In an attempt to deal with these feelings, they will often develop passive-dependent relationships.

24/42

When persons with the 24/42 code type come to the attention of professionals, it usually is after they have been in trouble with their families or with the law. They are impulsive and unable to delay gratification of their impulses. They have little respect for social standards and often find themselves in direct conflict with societal values. Their acting-out behavior is likely to involve excessive use of alcohol, and their histories often include alcoholic benders, arrests, job loss, and family discord associated with drinking. 24/42 persons feel frustrated by their own lack of accomplishment and are resentful of demands placed on them by other people. They may react to stress by drinking excessively or by using addictive drugs. After periods of acting out, they express a great deal of remorse and guilt about their misdeeds. They may report feeling depressed, anxious, and worthless, but their expressions do not seem to be sincere. In spite of their resolutions to change, they are likely to act out again in the future. It has been noted in the literature that when scales 2 and 4 are grossly elevated, suicidal ideation and attempts are quite possible. Often the suicide attempts are directed at making other people feel guilty. When they are not in trouble, 24/42 persons may seem to be energetic, sociable, and outgoing. They create favorable first impressions, but their tendencies to manipulate others produce feelings of resentment in long-term relation.

(Dahlstrom, Welsh, & Dahlstrom, 1979)

24's

This code group has not been reported very extensively in the literature. Guthrie found a small subgroup of medical patients with this profile type. They showed depressive patterns, usually associated with agitation and restlessness. Some men with this pattern reported severe epigastric distress, with positive evidence on X ray of ulcerative conditions. Some of these patients, particularly with scale 2 and several other scales at a primed level, were clearly psychotic. Only one case had a well-established history of alcoholism and drug addiction. There were some other indications of psychopathic backgrounds in the group, however. At the time of testing, these patients appeared to be seriously seeking help from the physician and treatment was moderately successful. In psychiatric populations this pattern is likely to be found in a psychopathic person who is in trouble and appears at a medical center. Alcoholism, addiction, and legal difficulties are frequent in the patterns of these cases. Although the distress of these persons seems genuine it does not reflect internal conflicts that they may be suffering so much as situational pressures from legal confinement, psychiatric commitment, or close supervision and scrutiny. While the insight these persons show at this time may be good and their verbal protestations of resolve to do better may seem genuine, long-range prognosis is poor. Recurrences of acting out and subsequent exaggerated guilt are common. Note the inclusion of 247 pattern in Marks and Seeman's 274-247 code type. Chapter 3 lists the defining characteristics for this pattern. (Dahlstrom, Welsh, & Dahlstrom, 1979)

2-4 See also the 4-2 combination, p. 147,

1. People with this pattern are impulsive and unable to delay gratification. They feel frustrated by their own lack of accomplishment and are resentful of demands placed on them by others (Graham, 1977).
2. They tend to have behavioral difficulties which have developed over time (Hovey & Lewis, 1967).
3. They may be remorseful after acting out but not seem sincere about this remorse (Graham, 1977).
4. They tend to run from people's expectations for them and from their own problems.
5. The person cannot take pressure in therapy, and if it is applied, he/she will leave. Prognosis for change is poor.
 - a. He/she will change jobs or leave town but will not confront the therapist directly.
 - b. If the person cannot run from therapy, he/she will tend to have a "spontaneous" recovery.
 - c. He/she will be superficially deferent to the therapist.
6. If these scales are both highly elevated, suicidal ideation and attempts may occur. The attempts are usually to get other people to feel guilty (Graham, 1977).

7. Lewandowski and Graham (1972) found in one study that patients with this pattern were significantly more sociable than patients with other patterns.
8. Gynther, Altman, and Warbin (1972) and Gynther, Altman, and Sletten (1973) have found psychiatric patients with this pattern, 2-4/4-2, are apt to show less psychotic pathology and fewer defects in judgment and orientation than the typical state hospital inpatient. Both males and females are more likely to be diagnosed as alcoholic than patients with other MMPI patterns. Females are more likely to show depressive symptoms and males are more likely to have had a job loss than the average patient. There may be a recent history of suicidal behavior.
9. Adolescents in treatment with the 2-4/4-2 pattern (Marks et al., 1974) were referred for treatment because of difficulty concentrating. They tended to resent authority figures, were argumentative, and afraid of involvement with others. They had a history of drug usage and tended to escape their problems by running away, using drugs, or attempting suicide. The Marks, Seeman, and Haller book should be consulted for further information concerning this profile.
10. Megargee and Bohn (1979) found a group of incarcerated criminals (Group George) with the 24/4-2 code type predominating (53070 of the group). They did not have extensive criminal records, were bright, and well educated. Many of the men were drug pushers but did not use drugs themselves. They seemed to be career criminals and in spite of making a good prison adjustment had a high recidivism rate.
11. In one study, this code type was consistently found in profiles of DWI offenders and alcoholics (Sutker et al., 1980).
12. In another study, the 2-4/4-2 profile occurred most frequently in four alcoholism treatment centers. It accounted for 12 to 21% of the profiles in any one facility (Schroeder & Piercy, 1979),
13. Kelley and King (1979a) found the 2-4/4-2 code type in a college counseling center. Clients with this profile were depressed, impulsive, and had a history of physical problems. Females were usually seen to have a personality disorder and to be in situational distress. Males had many characterological symptoms such as impulsivity, drug abuse, and criminal records, yet they were guilt ridden, depressed, and unable to sleep.
14. Clients in another college counseling center with this code were difficult clients with whom to work because they dropped out of therapy when pressure was put upon them to improve. Their main symptoms included depression, disturbed home life, few friends, and sexual problems. Therapists who used a supportive, non-demanding approach made more progress than therapists who used confrontive or uncovering therapies (Anderson & Bauer, 1985).

Description:

Depression, stimulation-seeking, substance abuse common, social, legal, family problems, immature, egocentric, ambivalent, self-pity, projection, manipulative, impulsive, disturbed family background common, suicidal

Possible Diagnoses:

Acute alcohol intoxication, Schizophrenia, Psychopathy, Antisocial pers. dis., Unsocialized Conduct dis., Adjustment dis.

Modifying Scales

- o Elevations on one or more Authority Problems (Pd2), Antisocial Practices (ASP), and Antisocial Behavior (Rc4) may indicate a history of conflicts with authority.
- o When Scale 4 elevations are mostly due to elevations on Social Alienation (Pd4) and Self-Alienation (Pd5), the profile reflects estrangement and a sense of isolation from others rather than rebellion or anger.
- o When Scale 1 is elevated third, physical symptoms may be present. They may use those physical symptoms to control or manipulate others.
- o When Scale 7 is elevated, anxiety is reduced through immediate tension reducing behavior, such as alcohol or drug consumption, gambling, or reckless spending.
- o When Psychomotor Acceleration (Ma2) is elevated, self-destructive impulsivity may be present, and suicide risk is heightened.
- o Elevation on Anger (ANG) would predict impulsive, angry behavior.
- o Elevations on MacAndrew Alcoholism-Revised (MAC-R), the Addiction Potential (APS), or Addiction Acknowledgment scale (AAS) would confirm addictive behavior.
- o Elevation on the Cynicism scale (CYN) would substantiate the alienation and distrust of the 2-4 profile.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Male

Low 0 Father conflict, aggressive or belligerent.

Nothing Low Introverted or self-conscious or socially insecure, lacks skills with the opposite sex, tense, unhappy, worries a great deal, insomnia.

- Note: Scale 4 coded high was infrequently associated with lack of skills with the opposite sex.

Female

Low 0 Anxieties, depressed, father conflict, indecisive, lacks skills with the opposite sex, socially extroverted, lacks academic drive, tense on examinations.

- Note: Scale 0 coded low was infrequently associated with depression and lack of skills with the opposite sex.

Low 1 Anxieties, depressed, father conflict, indecisive, lacks self-confidence, physical inferiority, lacks skills with the opposite sex, socially extroverted.

Low 3 Anxieties, depressed, father conflict, indecisive, lacks skills with the opposite sex.

Low 5 Anxieties, depressed, nervous, father conflict, rebellious toward home, mother conflict, indecisive, lacks skills with the opposite sex, socially shy, socially insecure, tense on examinations, wants answers.

- Note: Scale 4 coded high was infrequently associated with social insecurity.

Low 6 Anxieties, depressed, father conflict, indecisive, lacks self-confidence, lacks skills with the opposite sex, socially insecure, vague goals, nonverbal.

- Note : Scale 4 coded high was infrequently associated with social insecurity.

Low 7/8 Anxieties, depressed, father conflict, indecisive, lacks skills with the opposite sex.

Low 9 Anxieties, depressed, father conflict, mother conflict, indecisive, lacks skills with the opposite sex.

Nothing Low Anxieties, depressed, father conflict, indecisive, lacks skills with the opposite sex.

(Drake & Oetting, 1959)

o **Check:** *ANX, DEP, DEP1, DEP2, DEP3, DEP4, RC2, HEA3, ANG1, ANG2, ASP2, TPA1, LSE1, FAM1, FAM2, DISC, Dr1, Dr2, Dr3, Dr4, Dr5, Hy3, Pd1, Pd2, Pd3, Pd4, Pd5, Pa1, Sc2, Sc4, AAS, MDS.*

TREATMENT

Psychotherapy depends on whether the 24/42 individual is primarily a high 4 who has recently been caught or feels trapped between undesirable alternatives, or whether the 24/42 is reflecting a long-term personality adjustment. The high 4 individual who feels currently caught in an entrapping situation may need to experience “hitting bottom” in order to make serious changes. A subgroup of 24/42 individuals exhibits a lifestyle of chronic unhappiness, resentment, and bitterness, without antisocial acting-out behavior. They can be frustrating for their co-dependent spouses, but they do not necessarily act out antisocially. They do experience marital conflict and feel hopeless and trapped. They resist psychotherapy, often aggravating therapists because of their tendency to undermine any therapeutic suggestion with a defeated, “I’ve tried it, and it doesn’t work” attitude. Small, concrete homework assignments in the direction of change, and holding them accountable when they do not perform these assignments,

though in a gentle way, can be helpful. Help them see how they have lost trust in themselves so that, as an adaptive response, they refuse to “invest” in any change. Insight to help them see how they undermine themselves by acting out impulsively can be helpful, especially if they are bright. Look for childhood experiences of being emotionally let down and abandoned a number of times, which may have instilled in them a tendency to distrust not only relationships with others, but their own efficacy. With the high 4 individual whose 2 elevation is due to situational factors, help them see how they have “numbed themselves” as a way of surviving a childhood in which they felt defeated and trapped. Through insight, help them recognize when stress is building and rehearse ways to not act impulsively. This codetype is the most commonly occurring one in substance abuse rehab centers. Even if the *MAC-R* scale is not elevated, the use of chemical agents should be evaluated. Although firm intentions to change may be expressed, these individuals can be quick to feel defeated. They often drop out of therapy. A combination of firm support, limits, and insight, as well as predicting how they might act out, can be helpful. It is also important for the therapist to deal with the transference, specifically, their expectation that the therapist will abandon them.

Treatment: Seeks symptomatic relief. Relatively low motivation for treatment despite strong expressions of regret for past conduct and desire for change. Unreliable about keeping appointments and following through on agreements reached in therapy.

- Frequent diagnoses: passive-aggressive or antisocial personalities (especially with high 6), adjustment disorder with a depressed mood; if depression is chronic then anxiety, conversions, and depression (neurotic features) will be predominant (especially if Scales 1 and 3 are also high). If depression is reactive, this more likely represents an antisocial personality who has been apprehended; substance abuse may be either the primary difficulty or may occur in addition to the other disorders suggested earlier, extremely elevated 4 (above 90) a psychotic or prepsychotic process may be present especially if *F* and 8 are also high.
(Groth-Marnat, 2009)

Treatment Implications

A 24/42 code type is the most frequent pattern found in alcohol and drug treatment programs. As a result, persons with this code type should always be assessed for substance abuse, regardless of the setting or reason for referral. Often an acknowledgment by clients that they indeed do have a drug or alcohol problem and an appraisal into its impact on their lives are essential initial steps (check the AAS/Addiction Acknowledgment scale). This profile also suggests long-standing personality difficulties that often make therapy difficult. Although such people may promise to change and their guilt is generally authentic, their acting out is usually resistant to change. Effective therapy must include clear limits, a change in environment, warm supports, and continual contact. However, the prognosis for

long-term success in therapy is poor and the individuals will be likely to terminate when confronted with situational stress or when external motivators (e.g., legal) have been eliminated. Thus, some sort of external monitoring (i.e., legal or work-related) of their treatment, perhaps even conducting their treatment in a controlled environment, is advisable. Because peer influences are likely to have considerable impact, group interventions are likely to be more effective than individual treatment.

Therapy and Therapeutic Pitfalls

Therapy with 2-4 code types is difficult because they feel angry, defeated, and trapped with nothing to lose. They are fearful of getting invested in the therapeutic process because they are cynical about their therapist's caring and pessimistic that things will work out. They have lost trust in themselves and others and tend to avoid the emotional vulnerability of a therapeutic relationship. If the 2-4 profile reflects a recent trapped depression in the absence of a history of antisocial behavior, then antidepressant medications can be useful. Beware of energizing antidepressants, especially if clients complain of suicidal ideation. These individuals selectively report, so external validation that they are no longer using chemical substances is important. Be mindful of the interaction of medications with chemical agents. Behavioral therapy with concrete steps to help reduce self-destructive and self-defeating behavior will work best. Developing a contract for concrete, daily changes in behavior, anticipating self-defeating behaviors, and rehearsing prophylactic ones is more helpful than insight therapy. For the 2-3-4 code types, assertiveness training can help them express anger directly rather than passive-aggressively. Help them understand that they adapted to childhood rejection and abuse by role playing, manipulating, and avoiding intimacy.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Treatment and Self-Help Suggestions

1. Watch your tendency to get impulsive when stress builds. Try to rehearse some alternative behavior so that you don't drink, abuse drugs, or engage in self-destructive acts.

2. Resilience building: It is not necessarily your impulsivity that is a problem; at times it can mean that you are spontaneous, active, and social.¹ This same trait that is sometimes an asset can be hurting you right now because you are discouraged and impulsive. Make it a point to plan ahead. Regardless of the specifics, good planning involves the following:

- a. Problem definition: What am I dealing with? What is my first step?
- b. Focusing attention: Think of the steps—What do I do first? Strategy: First brainstorm, then create goals.
- c. Self-evaluation: Correct any errors.

d. Coping statements: I need to go slow, don't worry: worry doesn't help.

e. Reinforcement: Give yourself a reward.²

3. Force yourself to do something kind or caring for others, even though you won't feel like it. Alleviating others' suffering could help you feel better.

4. Instead of feeling guilt and remorse for past behavior, focus on one positive, healthy, self-affirming habit you would like to work on. For example, if you impulsively spend money, come up with a detailed action plan: cut up all but one credit card; shop only with cash; avoid the places where you have spent too much money in the past; before shopping make a list and stick to it. No matter how small, your sense of accomplishment can begin an upward spiral that will reduce your sense of guilt and hopelessness.³

¹ Impulsivity has generally been looked on in a negative light, but there are both functional and dysfunctional types of impulsivity. Functional impulsivity is associated with being carefree, spontaneous, and productive, whereas dysfunctional impulsivity involves acting without forethought and failure to plan ahead. Stress may be the factor that creates "noise" that interferes with the ability to use a methodical approach when it is needed (Dickman, 1990). By offering the client the possibility that his or her impulsivity is nothing shameful and by rehearsing the skills of methodical planning the client can develop the sense of mastery that comes from planning ahead.

² www.pent.ca.gov/pos/cl/str/basicformsofself-instructions.pdf

³ Resilience and positive emotion are not just the by-product of being "happy"; people become more satisfied in life because they actively develop resources for living well. The broaden-and-build theory of positive emotions suggests that even momentary experiences of success and positive coping fuel further change and an increase in the ability to meet life's challenges (Cohn, Fredrickson, Brown, Mikels, & Conway, 2009).

(Levak, Siegel, Nichols, & Stolberg, 2011)

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you are feeling trapped, unhappy, bitter, resentful, and unable to see a way out of your current situation. Perhaps you've recently experienced some difficulties because of your behavior and you feel angry with yourself. At other times you may feel angry with others, feeling that your situation cannot change unless others change or events beyond your control change. In some cases, people with this profile grew up in environments where authority figures were unreliable and untrustworthy. From an early age you've learned that you can't trust others, so that you've relied on yourself during times of stress. When stresses build, you can act impulsively and occasionally that gets you into the kind of trouble you may be experiencing now. Perhaps you've used chemical agents as a way of trying to feel better, or perhaps you took a shortcut that led to a series of negative events. It is no wonder you feel trapped and angry. You might want to feel like giving up or even hurting yourself. At other times you feel angry with the world and you feel unfairly treated. You may experience some feelings of depression, such as sad moods, difficulties with sleep, changes in appetite, and sex drive. You may have difficulty concentrating and completing things. When others become angry with you because you do not follow through, you may find yourself taking shortcuts, telling white lies, or even manipulating to get out of difficult situations. Currently you feel quite glum, trapped, and down on yourself. At times you feel hopeless and utterly defeated. Protecting yourself against being hopeful is understandable, given your current predicament. It is going to be hard for you to do some of the exercises your therapist wants you to do. You may find yourself agreeing to making changes, but then not being able to follow through. You may find yourself angry with your therapist for "pushing you" to do things that you feel are useless. Taking small daily steps towards a goal would be important for you. Learning to recognize when stress is building and not acting out impulsively would also be important. Try to rehearse stressful situations so that you develop habits that are not self-defeating or self-destructive. When you want to give up, force yourself not to. Working towards small goals can help you feel better about yourself. Work on avoiding chemical agents as a way of feeling better, because that may actually aggravate your depression.

Feedback Statements—Elevated Profiles (T-Score > 65)

Depressed or Trapped

Currently, your profile shows that you are feeling quite depressed and sad. There may be little in your life that seems to give you pleasure. Much of the time, you feel unhappy and negative but are unable to find ways to feel better. You are feeling trapped in your current situation, and it's hard for you to see a way out of it. You feel bitter and resentful that you are stuck in this situation, and you may feel that you have nothing left to lose because you have already lost a great deal.

Alienated or Relationship Problems

Your profile shows that right now you feel very disconnected from others and even yourself. You feel like you have no one to turn to and you feel alone, without a sense of community or support. Even if there are people who tell you they care about you, it's hard for you to trust them. You are probably experiencing a lot of relationship difficulties. You may experience conflicts with loved ones or with people with whom you work.

Feeling Victimized or Resentful

Currently, you may be feeling bitter and resentful, as if others have mistreated you. You may find yourself spending a lot of time thinking about how others have wronged you and how they have let you down. You may be feeling like a victim of circumstance, and at times you feel angry with the world and at other times angry with yourself.

Possible Legal Problems

In some cases, people with this profile are experiencing trouble with authority figures and perhaps even with the law. Your current depression and feelings of defeat may be due to a recent conflict. You may feel resentful and angry that you are in this position. In some cases, people feel this trapped, angry depression because they feel like victims of unfair rules and regulations.

Self-Defeating

People with your profile often give up, even as they're getting ahead and things are starting to improve. You may find yourself impulsively doing things that defeat your goals, such as not paying bills, being late, and missing appointments. When stress builds, you may be unaware of how self-defeating you are.

Hostile, Sarcastic, Argumentative

Because you feel angry, trapped, and bitter, you might lash out at people, especially as stress builds. Because you're afraid to trust people, you might push them away with a sarcastic, angry demeanor. You are quick to argue, and you can get stubborn and negative with others. It's as if you're angry with everyone so that no matter what people say you have a desire to argue and fight with them.

Impulsive or Addictive Personality

People with your profile can be quite impulsive as stress builds or even when you are feeling good. Your impulsivity might lead you into self-destructive and hasty acts, which later make you feel guilty and down on yourself. People

with your profile tend to develop addictions. Because you have a tendency to be impulsive and act out when you're in pain, you may grab at anything that makes you feel better. It may be drugs, alcohol, sex, or something else that is immediately soothing. When you use chemical agents, it may make you more impulsive and more self-defeating.

Manipulative or Demanding

People with your profile often feel they have to manipulate others to get their needs met because they don't trust and don't think anyone really cares. Because you feel as though you have been unfairly treated and you feel trapped, you may come across as quite demanding, and people may see you as using the threat of your bad temper as a way to get what you want.

Lifestyle and Background Feedback

People with your profile sometimes grew up in environments where, from an early age, they had to be self-reliant. Perhaps your parents were unavailable or unreliable, selfish, or unreasonable. From an early age, you may have learned to be independent, to not trust others with your vulnerable feelings, and to manipulate people to get your needs met. As a child, you may have felt the only way you could be heard was if you did something impulsive and angry or if you lashed out or manipulated others. It's as if you're afraid to care, to let your guard down, and to invest yourself in changing your life. Recently, you may have experienced a setback or loss, which has left you feeling more alone and with no one to turn to. Numbing yourself and being cynical were adaptive ways of protecting yourself when you felt you had no one to lean on. Currently you may be experiencing similar feelings.

Normal-Range Feedback (T-Score 50 – 65)

Your profile is in the normal range. However, it shows you feel somewhat trapped or defeated at this time. At times you feel angry and negative toward others and have low tolerance for frustration. Other times you feel angry with yourself. You may keep people at a distance, fearful of being let down by them. Currently you appear to be feeling frustrated and angry. You may find it hard to persevere in the face of frustration and to be warm and pleasant with those around you. A recent setback with feelings of disappointment in yourself and others or some other letdown has left you feeling this way. You avoid being emotionally vulnerable with people out of fear that they will hurt you or let you down. Sometimes people with your profile use drugs and alcohol as a way of relieving stress. When they do, it seriously increases the risk of behaving in an impulsive and self-defeating way.

(Levak, Siegel, Nichols, & Stolberg, 2011)

243/423 Codes

The addition of Scale 3 adds hysterical defenses to the trapped, angry, self-defeating 24/42 codetype. Consequently, these individuals manifest some denial, repression, and the ability to role-play in order to avoid rejection. They are self-sacrificing, but angry about it. They feel trapped and sad, but are also inclined to relieve tension impulsively, as one would expect from Scale 4 elevation's impulsivity. The Scale 2 and 3 elevations act as a control for Scale 4 acting-out behavior. Consequently, the acting out is more interpersonal and self-centered. These individuals may have eating disorders, chemical addiction problems, and impulsive, angry episodes that they later deny. Anger tends to be expressed in more symbolic ways and through passive-aggressive behaviors and perhaps talking behind people's backs. In some people, anger might be expressed in episodic explosive episodes, especially if the *O-H* scale is elevated above a raw score of 17. The 243/423 individual tends to be oral dependent. They are depressed and hungry for love and approval, yet afraid that being emotionally vulnerable will lead to abandonment. This combination of scale elevations suggests an approach-avoidance conflict, with a desire to please others by what they perceive is self-sacrifice, but at the same, anger at not having their needs met. They go through life manipulating others to get their emotional needs met, and pretending to fit in to avoid rejection and conflict, yet distrusting others' caring towards them because they have played a role in order to obtain it. They project their own manipulateness onto others. The 243 individual can be frustrating to live with because they crave reassurance but do not accept it, and are chronically resentful, rationalizing their acting out as a response to not having their needs met.

o Like 2-4/4-2 but with better socialization and unstable controls. See 2-3/3-2, 2-4/4-2, 3-4/4-3. Check *O-H*.

TREATMENT

This profile is characterized by early childhood experiences of rejection or emotional abuse and, if Scales 4 and 3 are significantly elevated, physical abuse. As an adaptive response, they learn to role-play, becoming what others expect of them to avoid rejection and conflict. Psychotherapy should focus on helping them recognize what they want versus the role they feel they have to play for others. They also need to recognize anger in themselves and express it in a modulated direct way, rather than in manipulative ways. Assertiveness training to learn not to rely solely on manipulateness can be helpful. Catharsis around past rejections, perhaps from an explosive, discounting parent would be useful. Developing empathy towards themselves as emotionally abused children would help them recognize how they defend against "feeling" by numbing and roleplaying. These individuals lack insight and can express inconsistent verbalizations. They want to please and have people like them, but at the same time, they are angry. Helping them recognize how to integrate these two sides of themselves would be important. In some cases,

this is primarily a depression profile, with the 43 elevations reflecting overcontrol and role-playing, perhaps as a way of dealing with the depression. If the depression is more palpable, an antidepressant medication may be indicated.

THERAPEUTIC FEEDBACK LANGUAGE

Your profile shows that you are currently experiencing a moderate amount of distress. You may be feeling trapped and angry as well as anxious and tense. Often people with your profile grow up in environments where the caretaker was explosive, discounting, or even abusive. You may have experienced periods where you felt hopelessly trapped and unable to get your needs met. Perhaps from an early age you felt defeated and unable to think about your wants because you had to role-play being somebody that your parents wanted you to be, rather than who you were. From an early age you learned to try to please others, to fit in, and to avoid rejection by playing the correct role. You may have difficulty even knowing what you want versus what you are “supposed to do” in order to please others. You may find yourself being manipulative, trying to get others to take care of you, but at the same time not trusting them. You may be experiencing periods of depression when you feel sad, unhappy, and trapped, with low energy. Sleep and eating difficulties and disturbances in weight and sex drive can sometimes occur with this profile. You may have experienced some recent setback or loss that has left you feeling sad and unhappy, but at the same time forced to play the right role to fit in and to avoid upsetting others. You may not even recognize when anger is building inside of you, and you may express it in roundabout, symbolic, or even passive-aggressive ways. You might be so concerned that expressing what you want could lead to rejection that you feel you have to manipulate others in order to get your needs met. Your therapist may want to suggest medication to help you with some of the symptoms, particularly the sad and unhappy feelings. Talk about any recent or past experiences where you felt trapped, rejected, and discounted, so that you had to learn to play the right role in order to fit in. Learn to observe when you act impulsively to try to relieve your stress. Do you eat too much or use chemical agents as a way of self-soothing, or do you act out sexually? Talk to your therapist about what kinds of impulsive behaviors you engage in order to feel better. Learning to recognize anger and expressing it directly could be helpful to you.

Normal-Range Feedback (T-Score 50 – 65)

Your profile is in the normal range. However, it shows you feel somewhat trapped or defeated at this time. At times you feel angry and negative toward others and have low tolerance for frustration. Other times you feel angry with yourself. You may keep people at a distance, fearful of being let down by them. Currently you appear to be feeling frustrated and angry. You may find it hard to persevere in the face of frustration and to be warm and pleasant with those around you. A recent setback with feelings of disappointment in yourself and others or some other letdown has left you feeling this way. You avoid being emotionally vulnerable with people out of fear that they will hurt you

or let you down. Sometimes people with your profile use drugs and alcohol as a way of relieving stress. When they do, it seriously increases the risk of behaving in an impulsive and self-defeating way.

245 Code

Male

Low 0 Father conflict, wants reassurance only, worries a great deal, aggressive or belligerent.

- Note: Scale coded low was infrequently associated with worrying a great deal. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, lack of skills with the opposite sex, being nonresponsive or nonverbal, tension.

Low 1 Home conflict, wants reassurance only, restless, worries a great deal.

Low 3/6/7/8/9 Wants reassurance only, worries a great deal.

Nothing Low Introverted or self-conscious or socially insecure, lacks skills with the opposite sex, home conflict, wants reassurance only, tense, unhappy, worries a great deal, insomnia.

- Note: Scale 5 coded high was infrequently associated with tension; Scale 4 coded high was infrequently associated with lack of skills with the opposite sex.

Female

Low 0 Anxieties, depressed, father conflict, indecisive, lacks skills with the opposite sex, socially extroverted, tense on examinations, lacks academic drive.

- Note: Scale 5 coded high was infrequently associated with anxieties, depression, and father conflict; Scale coded low was infrequently associated with depression and lack of skills with the opposite sex.

Low 1 Anxieties, depressed, father conflict, indecisive, lacks self-confidence, physical inferiority, lacks skills with the opposite sex, socially extroverted.

- Note: Scale 5 coded high was infrequently associated with anxieties, depression, father conflict.

Low 3 Anxieties, depressed, father conflict, indecisive, lacks skills with the opposite sex.

- Note: Scale 5 coded high was infrequently associated with anxieties, depression, father conflict.

Low 6 Anxieties, depressed, father conflict, indecisive, lacks self-confidence, lacks skills with the opposite sex, socially insecure, vague goals, nonverbal.

- Note: Scale 4 coded high was infrequently associated with social insecurity; Scale 5 coded high was infrequently associated with anxieties, depression, father conflict.

Low 7/8 Anxieties, depressed, father conflict, indecisive, lacks skills with the opposite sex.

- Note: Scale 5 coded high was infrequently associated with anxieties, depression, father conflict.

Low 9 Anxieties, depressed, father conflict, mother conflict, indecisive, lacks skUs with the opposite sex.

- Note: Scale 5 coded high was infrequently associated with anxieties, depression, father conflict.

Nothing Low Anxieties, depressed, father conflict, indecisive, lacks skills with the opposite sex, distractible in study.

- Note: Scale 5 coded high was infrequently associated with anxieties, depression, father conflict.

(Drake & Oetting, 1959)

246/264/426/462/624/642 Codes

Code-Type 2-4-6

Descriptors

Complaints

Depression (crying spells, sleep problems, somatic symptoms), hopelessness, fatigue, weight changes, anxious, alienated, relationship problems, authority conflicts, feeling overwhelmed, dissatisfied

Thoughts

Rationalizing resentments, wounded, bitter, critical, blaming, insecure, frustrated, pessimistic, guilty, anxious

Emotions

Resentful, trapped, angry, sad, irritable, passive-dependent, argumentative

Traits and Behaviors

Extreme sensitivity to criticism or demands, withdrawn, impulsive, addictive personality, manipulative, aggressive, self-defeating, demanding

(Levak, Siegel, Nichols, & Stolberg, 2011)

Therapist's Notes

In the average to moderate range, 2-4-6 individuals work hard to be above criticism. They are sensitive, easily hurt individuals who anticipate resentment and have difficulties asserting themselves. In some cases, the 2-4-6 is a

distinct personality type, and, in other cases, it reflects someone with a 4-6 personality who has recently suffered a setback or loss, resulting in a current depression. 4-6 individuals are vulnerable to occasional depression because of their tendency to create conflict in the way they approach life: vigilant for how they are going to be taken advantage of or somehow unfairly treated. The 2-4-6 profile suggests the typical symptoms associated with depression; however, it is an angry, hurt, and wounded depression in which individuals feel mistreated and taken advantage of. These individuals doubt themselves and allow others to be more assertive, but then they ruminate about having been devalued. Anxious and insecure, they tend not to assert themselves until they feel resentful and entitled to explode or to confront others in an angry, blaming outburst. Resentments are stored until the person feels justified in a confrontation, by which time they are deeply hurt and angry. In psychodynamic terms, the aggressive behavior is a defense against their strong dependency needs. Individuals with this code type may have adapted to a childhood of feeling criticized, judged, emotionally deprived, and unfairly treated. They may have felt trapped by authority figures who demanded a great deal from them but were emotionally withholding, rejecting, or indifferent and rarely positive or rewarding. Perhaps in an attempt to preempt harsh judgment, they adapted by becoming perfectionistic and self-critical but, at the same time, felt unfairly treated and resentful. They are argumentative and critical of others, as if they need to protect themselves by pointing out what others are doing wrong. Going through life storing resentments and anticipating unfair treatment leads them to come across as argumentative and stubbornly demanding; they are often seen as unforgiving and tend to hold grudges for long periods of time. Their expectation of unreasonable treatment often leads to a self-fulfilling prophecy. As marital partners, they are chronically dissatisfied, spend long periods of time feeling hurt and unfairly treated, and have difficulty asking for what they want from their partners in a reasonable way. They are often quite sensitive, and their feelings are easily hurt; in some cases, their sensitivity can shade toward paranoia, misinterpretation of others' motives, and feelings of being personally exploited. Loyalty is extremely important to them, so breaches of loyalty by others can lead to quick termination of relationships.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Lifestyle and Family Background

In the 2-4-6 personality type, there is often a family history of feeling unfairly treated and criticized. Many have had childhoods with cold, aloof, and even punitive parents who were quick to criticize and judge and slow to be supportive and emotionally warm. In some cases, they may have experienced harsh discipline and, in other cases, parental rejection. As children, they may have felt that it was impossible to please a parent. Unable to express anger directly due to the threat of punishment or emotional withdrawal, they tend to be passive-aggressive with periods of

angry silence and resentment. Precipitating circumstances for the onset of depression may be a recent loss that they perceive as the result of others' unfair, unreasonable, and vindictive behavior.

(Levak, Siegel, Nichols, & Stolberg, 2011)

o Like 2-4/4-2 but more anxious. Bitter, resentful, and rationalizing, but also dependent, with strong needs for affection. Passive-aggressive, schizotypal, avoidant, or dependent features, or a combination of these. Possibility of psychotic, especially paranoid, ideation. More alienated; less adequate controls. Depression, when present, is more externalized. Look for demandingness and blaming, even blaming others for depression; marital and sexual conflict. See 2-6/6-2; 4-6/6-4.

Modifying Scales

- Elevations on Bizarre Mentation (BIZ), Psychoticism (PSYC), Ideas of Persecution (RC6), or Aberrant Experience (RC8) may indicate depression with psychotic and paranoid features.
- Often, Anger (ANG) is not elevated, reflecting withdrawn, passive, but angry and resentful depression. When ANG is elevated, then anger is likely expressed as brittle, irritated outbursts toward people, usually after the accumulation of a number of resentments.
- When Authority Problems (Pd2) or Antisocial Behavior (RC4) is elevated, then conflicts with authority figures would be more prominent and more vocal and impulsive, especially if ANG is also elevated.
- When Persecutory Ideas (Pa1) is elevated higher than the Poignancy (Pa2) and Naïveté (Pa3), the depression may have a paranoid quality. Rule out any recent legal difficulties or interpersonal conflicts that could explain feelings of being attacked and criticized. Research suggests that people undergoing legal difficulties, especially if they feel unfairly accused, often elevate Pa1 (Nichols & Greene, 1995). Elevation on Pa2 would confirm the sensitive, hurt, and wounded quality of the depression.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Male

Low 0 Father conflict, worries a great deal, aggressive or belligerent.

- Note: Scale coded low was infrequently associated with worrying a great deal.

Low 1/3/5/7/8/9 Worries a great deal.

Nothing Low Introverted or self-conscious or socially insecure, lacks skills with the opposite sex, tense, unhappy, worries a great deal, insomnia.

- Note: Scale 4 coded high was infrequently associated with lack of skills with the opposite sex.

Female

Low 0 Anxieties, depressed, indecisive, father conflict, lacks skills with the opposite sex, socially extroverted, resistant in the interview, 8-|- conferences, tense on examinations, lacks academic drive.

- Note: Scale coded low was infrequently associated with depression and lack of skills with the opposite sex.

Low 1 Anxieties, depressed, indecisive, lacks self-confidence, physical inferiority, father conflict, lacks skills with the opposite sex, socially extroverted, 8+ conferences.

Low 3 Anxieties, depressed, indecisive, father conflict, lacks skills with the opposite sex, 8+ conferences.

Low 5 Anxieties, depressed, nervous, indecisive, physical inferiority, father conflict, mother conflict, rebellious toward home, lacks skills with the opposite sex, socially shy, socially insecure, 8+ conferences, wants answers, nonresponsive, tense on examinations.

- Note: Scale 4 coded high was infrequently associated with social insecurity.

Low 7/8 Anxieties, depressed, indecisive, father conflict, lacks skills with the opposite sex, 8+ conferences.

Low 9 Anxieties, depressed, indecisive, father conflict, mother conflict, lacks skills with the opposite sex, 8+ conferences.

Nothing Low Anxieties, depressed, restless, indecisive, father conflict, lacks skills with the opposite sex, 8+ conferences.

(Drake & Oetting, 1959)

TREATMENT

Therapy and Therapeutic Pitfalls

The 2-4-6 is a hurt, trapped, wounded, but self-righteous depression. These individuals feel that others or external situations are the cause of their depression, and they exhibit a sense of self-righteousness about their suffering. They feel justified in being depressed and resent any attempts to counter their feelings. Initially, empathy for their suffering will create a therapeutic alliance, and attempts to point out that blame for their suffering is unproductive would quickly be seen as unsupportive and judgmental. People with a 2-4-6 are difficult to treat because their anger and blame creates countertransference in the therapist. Reframing their resentments as manifestations of pain and suffering can help in maintaining empathy toward them and in avoiding negative countertransference.

Scale 4 elevations and excessive use of alcohol and chemical agents complicate their response to medication. In the absence of a history of acting out, conflicts with authority, and lifelong resentments, this code type may reflect a situational depression, which is amenable to antidepressant medications. Once the depression is alleviated, the

anger, resentment, and even paranoid sensitivity can diminish. In some cases, antidepressants are rejected because they feel a loss of protective vigilance. Psychotherapy combining insight, catharsis, and education about how to express demands without blame or judgment can be useful. Assertiveness training—teaching them to express desires without waiting until resentments build—can help with anger and depression (Smith, 2002). Catharsis around hurtful events, self-empathy, and role playing the expression of anger directly could relieve some of the hurt and resentment. Explore specific childhood events around being treated unfairly.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Treatment and Self-Help Suggestions

1. Role play telling the people who hurt you in your childhood about your pain and anger, verbalizing anger at those who mistreated you. Allow yourself to experience what it felt like at the time.
2. Explore your current situation to see how you feel trapped and how you feel you can't get out of the trap unless other people change. Find small, specific ways you can start changing your behavior to get out of the current trap.
3. Avoid alcohol or chemical agents as a way of relieving your depression and hurt; substitute healthier ways of coping instead. Beginning each day with exercise and following a healthy diet can help curb more self-destructive impulses. If your body is healthy and in good physical shape, you're better able to handle emotional stressors in your life.
4. Eating a healthy diet, exercising regularly, getting enough sleep, getting massages, and pampering yourself are all good ways to take care of your body and to begin a positive "upward spiral."¹
5. Work with your therapist to identify some of the most distressing and negative "intrusive" thoughts that you have. "Thought stopping" is an effective technique you can practice to help you prevent these types of unwanted thoughts that can make you feel depressed or angry. Several forms of thought stopping are effective; one quick technique involves picturing or saying out loud, "Stop," whenever you experience these types of unwanted thoughts. You then replace the thought with a pleasant image or affirmation that is more positive (e.g., "I have felt this way before, and I know I can handle this").²
6. Resilience building: Assertiveness training can be an effective component of stress management and mood regulation.³ *Assertiveness* is an honest and direct expression of your own desires and thoughts while still respecting the thoughts and feelings of others. An *aggressive* response ignores the feelings of others, whereas a *passive* response is the failure to express your own wants and needs. Think of examples either in your own life or something you have observed that illustrate different styles of communication, and then role play assertive responses with your therapist.

7. Resilience building: Practice using your “signature strengths”—qualities about you that feel “authentic,” that energize you, and that you feel competent and satisfied about.⁴ Examples might include bravery, tenacity, curiosity, creativity, critical thinking, and street smarts. The following Web site can help you identify your own signature strengths: www.authentic happiness.sas.upenn.edu/questionnaires.aspx

¹ Ilardi (2009) points out that nearly one in four Americans will suffer from major depression at some point in their lives, which is in part an artifact of modern-day lifestyle: sleep deprivation, poor nourishment, and stress. He advocates a diet rich in omega-3 fatty acids, exercise, natural sunlight, and ample sleep as part of a lifestyle to combat depression. Additionally, studies in neurobiology find evidence for the positive and antidepressant effects of exercise and healthy diet on the brain (Duman, 2005).

² Many mindfulness-based therapists have criticized thought-stopping technique as a counterproductive type of thought suppression, but an overview of the literature suggests that, although global thought suppression may be unhealthy, the specific type of thought stopping of unwanted thoughts is highly effective as one of the tools in a cognitive-behavioral model for the treatment of mood disorders (Bakker, 2009).

³ Many everyday problems with stress and emotional regulation can be directly attributed to interpersonal problems such as conflict with coworkers, coping with roommates or loved ones, or trouble with authority figures. Learning to communicate assertively is a cornerstone of more effective and satisfying interactions and subsequent improvements in mood (Smith, 2002).

⁴ *Character Strengths and Virtues: A Handbook and Classification* lists 24 strengths that are intended to be used to help people define and focus on what makes life worthwhile and vibrant—a manual to help balance out the preponderance of books about psychological disorders (Peterson & Seligman, 2004). (Levak, Siegel, Nichols, & Stolberg, 2011)

THERAPEUTIC FEEDBACK LANGUAGE

Feedback Statements—Elevated Profiles (T-Score > 65)

Depression or Hopelessness

Your profile shows that currently you are feeling quite depressed. You may exhibit typical symptoms of depression such as feeling tearful, crying, and sadness. You may experience sleep problems, either early morning awakening or

being unable to get to sleep. Your profile suggests that you are feeling defeated, perhaps even hopeless and pessimistic about the future. It's hard to see much positive in your life right now, and this may rob you of energy and drive.

Fatigue or Weight Changes

Much of the time you may feel tired and depleted, and even a good night's sleep may leave you without any real zest for the day. Tiredness makes even small daily tasks difficult to accomplish. You may be experiencing either weight gain or loss, and you may find yourself eating even when you're not hungry or uninterested in foods that you previously liked. Sometimes, people with this kind of depression can become so tense that they find some relief in purging after they eat.

Anxious

You may find yourself experiencing anxiety without knowing exactly why and what you are worrying about. You may feel a sense of dread, as if something bad could happen. Your anxiety may increase in situations where you feel others could be critical or judgmental of you.

Relationship Problems or Alienation

It may be hard for you to feel connected to others, and you may lack a sense of belonging. Because you feel hurt and let down by others, you may have trouble trusting people in general. Expecting others to hurt you may make you argumentative and demanding, leading others to resent you. Ready to protect and defend yourself, you come across as touchy, leaving others feeling criticized or judged by you. It's as if you're going through life ready to fight for your rights because they have been violated in the past.

Resentful or Trapped

Currently, you feel quite resentful and mistreated. You feel as though others have hurt you and have done things to you that have left you feeling unfairly treated and trapped in your current situation. It's hard for you to give yourself permission to be angry, so you tend to hold in resentments until you feel you are more than justified in expressing them. However, that means that you accumulate resentments and wait until you have built a case against someone before you give yourself permission to express how you feel.

Critical or Blaming

You may find yourself thinking and analyzing others' behaviors and feeling quite critical of them. If you expect to be criticized or blamed, it's understandable that you look for ways to criticize others as a natural protective response. You may spend time thinking about how others are to blame for what has happened to you and for how you feel. However, this type of self-protection might lead you into conflict with others, which is painful to you.

Guilty or Withdrawn

Even though you feel you have been unfairly treated and are angry, you also experience periods where you feel guilty and self-critical. Being sensitive to criticism, judgment, and even attack will lead you to withdraw to protect yourself. When you are hurt or angry, you may withdraw into silence because you are afraid to express anger in case it makes things worse.

Irritable, Angry, Argumentative

You experience anger and sadness a lot of the time, even in situations where others may be feeling happy and positive. Much of the time, you may feel irritable because you are frustrated in your attempts to get what you want. Minor upsets can quickly make you angry. You may find yourself sarcastic, verbally cutting, and argumentative toward others or perhaps just aloof and cold.

Impulsive or Addictive Behaviors

As stress and tension accumulate, you may impulsively relieve stress by eating, drinking, or spending money. Your impulsivity can be self-destructive or self-defeating. Chemical agents can aggravate your recklessness and can become addictive.

Lifestyle and Background Feedback

People with your profile often grew up in environments where they felt unfairly treated, judged, and violated. You may have had a parent that was particularly critical, dominant, and controlling. From an early age, you tried to be above criticism, and you tried to do the right thing to avoid rejection, criticism, and even attack. You go through life careful to protect yourself against people who might harm you or make unreasonable demands. It's hard for you to trust others' motives, so you may be suspicious of people even when they are being nice to you. This makes sense given the way you grew up—always having to protect yourself and guard against being mistreated. Now, it's hard for you to trust others' motives, to let your guard down, and to let yourself get emotionally involved. When people treat you well you wonder about their ulterior motives. You protect yourself against being hurt by maintaining a protective wall, although others may see you as cold and aloof.

Normal-Range Feedback (T score 50 to 65)

Your profile is in the normal range. People with your profile work hard to do things the right way and to be above criticism. You may have experienced situations where people have treated you unfairly and have not given you the recognition and credit you deserve. You are sensitive to unfairness and to any undeserved criticism. You go through life mindful of protecting your boundaries, as if you have felt they have been violated. You may find it difficult to ask for help and stand up for yourself. Because you want to be above criticism, you don't ask for what you want until you feel justified in doing so, by which time you are frustrated, resentful, and angry. Perhaps a recent loss, setback, or criticism has restimulated feelings of being wounded and unfairly treated. Because of your sensitivity to criticism, it may be hard to make decisions, to assert yourself, and to deal with your current situation.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Code-Type 2-4-7

Descriptors

Complaints

Worried, fearful, depressed (sad mood, anhedonia, sleep problems, eating problems, crying spells, sexual difficulties, difficulties with concentration and memory), weakness or somatic symptoms, panic, fatigue

Thoughts

Anxiety, phobias, ruminations, obsessional ideation or preoccupation with abandonment, self-doubt, suicidal ideation

Emotions

Anxiety or fearfulness, insecurity, fears of abandonment, guilt, fears of being controlled, panic attacks, irritable

Traits and Behaviors

Excitable, impulsive, tense or high-strung, self-defeating, need for affection versus need for independence, immaturity, alcohol or chemical addiction or eating disorders

(Levak, Siegel, Nichols, & Stolberg, 2011)

Therapist's Notes

In the normal to moderate ranges, 2-4-7 individuals are mildly tense and anxious, with a tendency to relieve stress through impulsive behavior. They have strong needs for affection and attention but also for independence. Because of this they suffer from ambivalence and have difficulty making decisions. Elevated 2-4-7 code types experience intense, mixed, and contradictory feelings of guilt, anxiety, self-doubt, and, at the same time, impulsive, angry, acting-out behavior. These code types have been called hyper-responsible, reflecting compulsive responsibility, anxiety, and selfdoubt. Individuals scoring high on Scale 4 tend to experience emotions and behaviors that are opposite those characteristic of Scales 2 and 7. They are impulsive and lack anxiety; they lack a sense of responsibility, empathy for others, and a sense of guilt. The 2-4-7 individuals express both sets of traits. They experience symptoms of depression and anxiety associated with Scales 2 and 7, but the addition of Scale 4 inclines

them to occasions of impulsive tension-reduction, which is usually destructive, either to themselves or others. They panic easily and are quite demanding of reassurance and emotional support, but these fail to provide them effective soothing. Because of their difficulties in trusting, 2-4-7s are afraid of abandonment and are fearful of not being loved and supported, but their impulsive and sometimes self-destructive anxiety/tension reduction often leads others to become exasperated and give up on them, confirming the client's view that relationship stability is not to be trusted. Their destructive and self-defeating acting out is followed by exaggerated feelings of remorse, guilt and self-doubt, which leads, in turn, to clinging, demanding behaviour as a way of seeking reassurance from those who have lost patience with them. They ruminate and have difficulty making decisions, especially about commitment to a relationship. Reflecting the 2-7 and the Scale 4 characteristics, they crave emotional security and reassurance but, at the same time, fear becoming emotionally dependent on others: they want reassurance and support, but they're afraid of being controlled. Even if the MAC-R, APS, or AAS is not elevated, 2-4-7s are vulnerable to other addictive behaviors that reduce their anxiety. Eating disorders, alcohol, drugs, gambling, and sexual addiction are all associated with their need for immediate, often impulsive, tension reduction. Depression and anxiety are the primary complaints. These clients can become quite despondent, crying easily if they feel vulnerable to losing a previously supportive figure. They also can complain of weakness, easy fatigability, and other somatic symptoms of anxiety. They are excitable and high-strung, unable to tolerate even small frustrations. Some report specific fears and phobias, and they tend to be highly ruminative, with obsessional ideation, usually around their close relationships. These individuals tend to be highly sexual, reflecting their need for reassurance, but they're ambivalent about intimacy because of their fears of emotional closeness. They show irritability and anger problems, as one would expect with individuals who are tense and high-strung. 2-4-7 individuals are quite manipulative, though not in the organized and Machiavellian way very characteristic of the 4-9 code type or the pure Scale 4 profile. Rather, their manipulations are impulsive, poorly thought through, and passive-dependent. They maneuver others into rescuing them and then undermine others' anger with exaggerated self-criticism. Under the influence of drugs or alcohol, they can be particularly self-destructive, especially when they feel vulnerable to being abandoned.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Lifestyle and Family Background

The conflicts of 2-4-7 individuals center upon relationships and responsibilities. The precipitating event usually involves a threat to one of their primary relationships. For males, there's usually been a very supportive and indulgent mother, which interfered with these clients learning basic impulse control and emotional self-regulation. Because the mother would rescue and indulge the child and then, at other times, become exasperated and

emotionally withdrawn, the child may have anticipated abandonment and loss of emotional support; thus, the profile reflects an insecure, anxious, angry, and demanding individual.

The same dynamic is true for females but often with the opposite-sex parent. Look for an indulgent, overprotective, but unreliable father figure who wasn't able to teach his daughter how to self-soothe and regulate her emotions.

He would either indulge her or withdraw from her. For both males and females, a crisis occurs when they perceive a supportive person in their life has become exasperated and withdrawn.

(Levak, Siegel, Nichols, & Stolberg, 2011)

This codetype reflects an anxious, acting-out and guilt-prone individual who is highly dependent on others. The 27/72 individual is characterized as being a hyper-responsible "worrier," whereas a 24/42 individual is experiencing anger and feeling defeated and depressed. The 47/74 individual shows a cyclical, almost compulsive, acting out pattern of behavior, followed by remorse and guilt. Consequently, when these patterns are combined, the codetype reflects a person who can alternate between periods of worry, anxiety, and even responsibility, followed by impulsive tension reduction as anxiety builds. After acting out, they then feel guilty, fearful, and seek reassurance. These individuals are chronically ambivalent about almost every aspect of their lives. For some it is an inability to let go of possessions, thus becoming a hoarder. For others it is holding on to relationships even as they begin new ones. Attachment to people or things engages their fear of losing them, so they derive little reward from the attachment unless it is threatened, whereupon they become energized to regain it. These individuals are very reactive to any threats to their security and become intensely worried, with numerous anxious preoccupations, when they feel threatened. Obsessive-compulsive thoughts and behaviors are common with this codetype. In response to setbacks, they become extremely self-critical, catastrophizing the situation and seeking others' reassurance, though not profiting from it. Because they fear failure, they are quick to be self-critical, perhaps as a way of preemptively undermining the anticipated criticisms by others. They equate failure with rejection. Other people respond to the 247 individual's self-negation with reassurance and support, but eventually becoming impatient with their inability to be soothed. These individuals are dependent, but they also fear emotional closeness and so exhibit passive-dependent manipulateness. They invite being rescued. Family or marital problems are likely. They have difficulty expressing anger out of fear of emotional abandonment, so their anger tends to be expressed passively. 247 individuals use guilt to manipulate others and undermine others' anger towards them by their own exaggerated self-criticism. Others can find this behavior annoying. Conceptually, the way the 247 deals with anger can be seen as similar to a child breaking his own toys as a venting of frustration, and a way of punishing caregivers. These individuals feel that life is a strain, and that they are getting a raw deal. Though symptoms of depression are present, these are often secondary to the individual's interpersonal difficulties and selfdefeating behaviors. Phobias, somatic

complaints, anxiety, tension, worry, and feelings of inadequacy are also present. These individuals are often underachievers and have difficulty with decisions because of their fear of making a mistake and somehow failing. They often self-medicate, even when the *MAC-R* is not elevated. Suicidal ideation and discomfort with the opposite gender may be present.

Men with this codetype are often highly dependent and immature, but can become verbally hostile when stressed. Typically they marry a strong, protective, and even domineering spouse. Interestingly, a high proportion of 274 individuals are the youngest child. Most were not behavior problems as children, suggesting that Scale 4 elevations contribute alienation and emotional distrust rather than acting out. Men with this profile often show a history of a close relationship with a mother figure who tended to indulge them, but failed to teach them personal efficacy because she was dominating.

Women have the same relationship, but with a male father figure, and often become involved with older married men. Some marry protective older men, reflecting their need for emotional security. When Scale 1 is coded fourth, these individuals complain of numerous vague somatic symptoms that are stress-related. If Scale 3 is elevated, there is more overcontrol and a tendency to play a social role in order to avoid rejection.

o Like 2-4/4-2 but with greater general distress; more anxious, insecure, and tending to be more compulsive rather than impulsive but nevertheless erratic. “Hyperresponsible but self-defeating, anxious and guilty but acting out, clinging and dependent but emotionally distancing” (Friedman et al., 2001, p. 263). More cognitive disruption and intrusive thoughts. Less overall alienation. More introjective. More dependent and submissive; may be self-flagellating in response to guilt, rejection, or loss; may undermine others’ anger toward them with self-criticism. Tend to catastrophize stressful events. Less alienation from family but stressful to spouses. Fewer substance abuse-related legal difficulties. Look for a cyclical pattern of acting out followed by periods of relative control; alcoholism; impulsive suicide attempts. See 2-4/4-2, 2-7/7-2, and 4-7/7-4. *MAC-R* scores may be false negative.

247/274/472

The modal diagnosis for persons with this code type is passive-aggressive personality disorder, and symptoms of depression and anxiety may be present. This is a very common code type among patients who abuse alcohol and/or other substances. Family and marital problems are common among these individuals. They may feel fearful, worried, and high-strung. They overreact to stress and undercontrol impulses. They tend to be angry, hostile, and immature, with strong unfilled needs for attention and support. They are in conflict about dependency and sexuality. They tend

to be phobic, ruminative, and overrideational, and they experience guilt associated with anger. Although they often have strong achievement needs, they are afraid to compete for fear of failing. They have difficulty enduring anxiety during treatment, and they may respond best to directive, goal-oriented treatment.

2-4-7 See the 2-7-4 combination, point 3, p. 109.

- Caldwell (1985) found that people with this pattern tend to get into trouble with alcohol even when the MAC scale (p. 309) is not elevated. They drink to relieve their depression. They may have episodic bouts of drinking.
- This pattern was found in a group of male alcoholics, Also found were the 2-1-3, 4-9, and 8-7-6 patterns (Conley, 1981).

Description:

Hostile, fearful, worried, avoidant, immature, ruminative, Phobic

Possible Diagnoses

Passive-aggressive pers., Alcohol abuse

Modifying Scales

- When Scale 1 is elevated, there are increased somatic preoccupations and symptoms associated with panic attacks and severe anxiety. The somatic symptoms will confuse the clinical picture in that they may be used as a way to manipulate others.
- When Scale 3 is elevated, clients may exhibit more control over immediate impulsive behavior and will attempt to play correct social roles to elicit caretaking from others.
- When Scale 6 is elevated, the individuals will be extremely sensitive to criticism and resentful and will have even more difficulties making decisions because the approach–avoidance conflict is aggravated by their fears of criticism and judgment.
- When Scale 9 is elevated, rule out the possibility of a cyclothymic mood disorder. Scale 9 coded fourth would predict more intense mood swings and more severe impulsive acting-out behavior. Scale 9 would energize the already high-strung, tense moodiness associated with the 2-4-7 code type.

- Elevations on the MacAndrew Alcoholism-Revised (MAC-R), Addiction Potential Scale (APS), and particularly the Addiction Acknowledgment Scale (AAS) would strongly indicate chemical addiction proneness associated with this code type.
- If the Pd2 subscale is elevated, look for more severe conflicts with authority figures. Typically, the 2-4-7 will complain of conflicts with parents and authority figures, but Pd2 elevations and elevations on the Antisocial Practices (ASP) and Antisocial Behavior scales (RCA) would predict antisocial acting out in response to buildups of stress.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Male

Low 0 Home conflict, father conflict, one interview only, tense, tense on examinations, indecisive, unhappy, worries a great deal, lacks knowledge or information, aggressive or belligerent.

- Note: Scale 0 coded low was infrequently associated with indecisiveness, unhappiness, and worrying a great deal.

Low 1 Home conflict, nonresponsive or nonverbal, tense, tense on examinations, indecisive, unhappy, worries a great deal, confused.

Low 3/5/6/8 Home conflict, tense, tense on examinations, indecisive, imhappy, worries a great deal.

Low 9 Home conflict, generally dependent, tense, tense on examinations, indecisive, unhappy, worries a great deal.

Nothing Low Introverted or self-conscious or socially insecure, lacks social skills, lacks skills with the opposite sex, home conflict, mother conflict, sibling conflict, nonresponsive or nonverbal, tense, tense on examinations, indecisive, unhappy, worries a great deal, insomnia, confused, poor rapport.

- Note: Scale 4 coded high was infrequently associated with lack of skills with the opposite sex.

Female

Low 0 Anxieties, depressed, insomnia, lacks self-confidence, indecisive, distractible in study, lacks academic drive, tense on examinations, lacks skills with the opposite sex, socially insecure (27), socially shy (27), socially extroverted (4-0), father conflict, rebellious toward home, 4 to 7 conferences.

- Note: Scale coded low was infrequently associated with depression, lack of self-confidence, lack of skills with the opposite sex, social insecurity, social shyness; Scale 4 coded high was infrequently associated with social insecurity.

Low 1 Anxieties, depressed, insomnia, lacks self-confidence, indecisive, physical inferiority, distractible in study, lacks skills with the opposite sex, socially insecure (27), socially shy (27), sociaUy extroverted (4-1), father conflict, rebellious toward home, 4 to 7 conferences.

- Note: Scale 4 coded high was infrequently associated with social insecurity.

Low 3 Anxieties, depressed, insomnia, lacks self-confidence, indecisive, distractible in study, lacks skills with the opposite sex, socially insecure, socially shy, father conflict, rebellious toward home, 4 to 7 conferences, cried in the interview.

- Note: Scale 4 coded high was infrequently associated with social insecurity.

Low 5 Anxieties, depressed, nervous, headaches, exhaustion, insomnia, lacks self-confidence, indecisive, distractible in study, tense on examinations, lacks skills with the opposite sex, socially insecure, socially shy, father conflict, mother conflict, rebellious toward home, 4 to 7 conferences, wants answers.

- Note: Scale 4 coded high was infrequently associated with social insecurity.

Low 6 Anxieties, depressed, insomnia, lacks self-confidence, indecisive, distractible in study, vague goals, lacks skills with the opposite sex, socially insecure, socially shy, father conflict, rebellious toward home, 4 to 7 conferences, nonverbal.

- Note: Scale 4 coded high was infrequently associated with social insecurity.

Low 8 Anxieties, depressed, insomnia, lacks self-confidence, indecisive, distractible in study, lacks skills with the opposite sex, socially insecure, socially shy, father conflict, rebellious toward home, 4 to 7 conferences.

- Note: Scale 4 coded high was infrequently associated with social insecurity.

Low 9 Anxieties, depressed, insomnia, lacks self-confidence, indecisive, distractible in study, lacks skills with the opposite sex, socially insecure, socially shy, father conflict, rebellious toward home, mother conflict, 4 to 7 conferences.

- Note: Scale 4 coded high was infrequently associated with social insecurity.

Nothing Low Anxieties, depressed, insomnia, headaches, lacks self-confidence, indecisive, distractible in study, vague goals, lacks skills with the opposite sex, socially insecure, socially shy, father conflict, rebellious toward home, sibling conflict, 4 to 7 conferences.

- Note: Scale 4 coded high was infrequently associated with social insecurity.

(Drake & Oetting, 1959)

TREATMENT

Often the precipitating event for this disturbance is the loss of dependency support by a protective caretaker, and it may replicate childhood experiences of emotional abandonment. Additionally, these individuals typically overreact to minor problems as though they were emergencies. They have difficulty expressing their emotions in a direct and clear way. Though depression is verbalized, and they may complain of sleep difficulties and other symptoms of

depression, anxiety tends to be more palpable. Others tend to see them as tense, high-strung, and jumpy. The profile has been described by Alex Caldwell as the “momma’s boy” profile for men and as the “daddy’s girl” profile for women. This reflects that they often experienced caretakers who would indulge them, but in an unreliable way that robbed them of a sense of personal efficacy. Parental inconsistencies instilled fears of abandonment in these individuals and, at the same time, a tendency to manipulate in order to get their needs met.

In therapy, these individuals need a great deal of reassurance but, as one would expect with Scale 4 elevated, they tend not to trust it. Consequently, they constantly seek love and reassurance, but they doubt its validity or reliability. They project their own manipulateness onto others and therefore distrust others’ motives. This often reflects childhood experiences of a caregiver who was highly involved, but who was unpredictable because of their own narcissistic needs or psychiatric illness. These individuals seek a lot of reassurance from the therapist, but tend not to follow through on advice. They tend to seek help for an immediate problem, such as getting the previously supportive person who has abandoned them back into their life. Many of them experienced physical illness at a higher than average rate in childhood. They also dated less often than average. Relaxation training and teaching them to recognize when stress is building can be useful, as can rehearsing stress-relieving behaviors that are not self-defeating or self-destructive.

Working on the transference is important, as the patient may withhold information from the therapist expecting the therapist to become impatient with them. If the therapist can earn the patient’s trust, so that they do not selectively report, then insight therapy can help the patient develop empathy for themselves as children who could not depend upon their caretakers. Insight therapy can help them realize how they demand nurturing from others in a co-dependent way. Sometimes therapy is brief because once anxiety is alleviated, they tend to lose motivation for continuing.

Therapy and Therapeutic Pitfalls

Clients with this profile are demanding of reassurance but tend to mistrust it. Treatment is often initiated when they are feeling panicked about some perceived failure or loss of emotional support. They may ask for reassurance and for specific advice but, because of their anxiety and tendency to act out, rarely follow through when these are given. Often, therapeutic suggestions are incompletely followed due to the clients’ difficulty in controlling their anxiety. When things go wrong, they have difficulty seeing their contribution and tend to externalize blame onto the therapist, in this way replicating their angry or dependant parental relationship. Cognitive Behavioral Therapy (CBT) (Butler, Chapman, Forman, & Beck, 2006) and therapeutic strategies that combine practical, solution-oriented guidance together with relaxation training, anxiety reduction, thought stopping, and self-soothing techniques can all be helpful.

The clients anticipate an impatient, rejecting therapist who becomes exasperated with them in the way that their opposite-sex parent did. It is important to deal with transference and their fear that the therapist is going to abandon them. These clients can also demand reassurance and immediate, practical advice and, if it fails, will subtly and sometimes overtly demand that the therapist rectify the problem. Once trust is developed, insight therapy can help them recognize how they replicate their childhood dynamics in seeking out relationships that are supportive yet controlling. Identifying their schemas or negative core beliefs can help them see how past events caused them panic with resulting self-defeating, tension-reducing behaviors. They can be misdiagnosed as manic-depressive because of mood swings from periods of intense anxiety and agitation followed by acting-out behavior and subsequent depression and guilt. Assess for suicidal ideation when they feel abandoned or guilty. The goal of therapy is to help them develop self-esteem by learning to control anxiety without acting out. Revisit moments of past panic (using mental imagery), and teach self-soothing techniques.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Treatment and Self-Help Suggestions

1. When people feel out of control because of their anxiety, panic attacks, and depression, their negative thinking tends to increase. Sometimes when overwhelmed and desperate, their self-esteem plummets, and they may even consider suicide. While the thought does not mean this is something you would act on, it would be important to share this with your therapist.
2. Certain types of negative and impulsive thinking can contribute to your anxiety.¹ Work with your therapist to identify some of the common “distorted thinking” that applies to you (e.g., *black-and-white thinking* is seeing things as one way or the other with no compromise; *mind reading* is assuming that people are thinking badly about you; *discounting the positive* is failing to look at the good that happens).
3. Resilience building: Work out with your therapist alternatives to acting impulsively when stress builds. Make a list of situations that cause you stress and lead you to act impulsively. In the calm of your therapist’s office, develop alternative strategies so that you rehearse better ways to relieve stress. Your therapist can help you create a “hierarchy” that relates to the stressful situation you are facing² and will also help you learn coping thoughts and statements (e.g., “I can be anxious and still deal with this,” or “This will pass”).

4. Try to remind yourself of how guilty you feel when you do something impulsively that backfires. Write it down so that the next time you want to do something impulsive you remind yourself of how you will feel later.
5. A lot of what people feel can be brought on by what they are thinking. People often talk to themselves “inside their head” without realizing it. See if you can identify your self-talk, watching for your negativity and your tendency to over-anticipate disaster. Observe to see if you’re telling yourself negative things about yourself and your life situation.
6. When it comes to this type of negative self-talk, thought stopping is a simple technique that can be mastered in less than a week of conscientious practice. List your troubling negative thoughts on a piece of paper. On the same paper list several pleasant thoughts (e.g., an upcoming vacation, your favorite hobby). Set aside 10 minutes a few times a day to practice: Start by giving free rein to the negative thought; imagine it clearly and in great detail. After a few minutes yell “Stop” loudly, and think of the pleasant thought you listed. Most people find that after a few days of practice they are no longer experiencing the negative thoughts.
7. If you experience physical symptoms of stress, work on relaxation techniques, meditation, and yoga as a way of relieving stress. These techniques are tools that, when practiced regularly, have been shown to reduce heart rate, muscle tension, and blood pressure and also to increase well-being.³ Your therapist can help you choose the method that will work best for you.
8. When you make a goal, try to follow it through. Watch your tendency to be impulsive. Don’t use drugs and alcohol as a way of relaxing.

¹ In a summary of 16 meta-analyses of CBT, there was substantial evidence for the efficacy of CBT for a number of mental health problems but especially for depression and anxiety (Butler et al., 2006).

While CBT has been criticized for being too “cold” and “mechanical,” it can be used in a way that is interactive and collaborative; the step-by-step nature of CBT can be helpful to create alternatives for impulsive behavior.

² Stress inoculation training (SIT) employs multiple components to reduce stress and to bolster coping

effectiveness. SIT involves three phases: (1) cognitive preparation; (2) skills acquisition and rehearsal; and (3) the application and practice of coping techniques. Meichenbaum and Deffenbacher (1988) provide an excellent outline of the theory, research, and procedures of SIT.

Relaxation techniques have been used for many years to combat the effects of stress, anxiety, and depression. These techniques can be easily incorporated into everyday routines, can be quickly taught, and can provide fast relief. While progressive relaxation, biofeedback, and meditation have all been shown effective, Eppley, Abrams, and Shear (1989) found that transcendental meditation (TM) produced significantly larger effect sizes than other forms of meditation and relaxation. (Levak, Siegel, Nichols, & Stolberg, 2011)

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that currently you are feeling on edge, tense, and anxious a great deal of the time. You may find yourself constantly worrying about something, fearful that something bad might happen. You might even experience some specific phobias. When things go wrong, it is easy for you to feel a sense of panic, as if your world is about to collapse. Often people with your profile grew up in environments where parents were controlling and yet unreliable in their emotional support. One of your parents may have been ill or unavailable in some other way, but caring and hands-on when they were available. Perhaps you never knew when you could rely on them, and when they did become involved, they were often too clinging and controlling, so that you never really learned emotional self-reliance. It is no wonder that you developed a constant sense of anxiety, as if waiting for something bad to happen, because you had no one you could rely upon. You never fully developed your confidence. People with your profile often marry a nurturing and supportive person who is also controlling. You might find yourself constantly afraid to lose that person's emotional support, but at the same time resenting them, feeling that they are too controlling. It is probably hard for you to make decisions because you are afraid of loss and the guilt you feel when things go wrong, and because you see every side of an issue. As stress builds, you may find yourself doing impulsive things to feel better, such as using chemical agents or something else that ends up making you feel guilty. Your constant inner anxiety and self-doubt may leave you feeling exhausted. It is hard for you to get a good night's rest, and you may experience physical symptoms of stress. Your therapist may want you to consider medication for your anxiety and teach you ways to switch off negative thoughts. Relaxation training, deep breathing, and yoga exercises could help you relax. Mindfulness therapy can help you become more aware of the positive things in your life. Work with your therapist to develop empathy for yourself as a child, understanding how having unreliable caretakers could have made you anxious and demanding of reassurance, and yet fearful of being controlled.

Feedback Statements—Elevated Profiles (T-Score > 65)

Worried, Panicked, Depressed

Your profile shows that, currently, you are extremely worried, on edge, tense, anxious, and preoccupied with what can go wrong next. Much of the time, you feel dread that, at any moment, something bad is about to happen that could lead to terrible consequences. You may find yourself easily panicked. Because you're so anxious, even small setbacks can cause you to feel a sense of alarm. Anxious, fearful, tense, and on edge, it's understandable that you wear yourself out and feel depressed, defeated, and blue, especially when things go wrong or if you feel emotionally abandoned by someone.

Phobias

When you live with a great deal of anxiety, it's easy for you to become phobic about something that has scared you. You may have fears of heights, bridges, confined spaces, open spaces, or large crowds. These phobias may become more intense when you are stressed by outside events.

Sleep Problems or Substance Abuse

Because of your anxiety and your current depression, you may find it difficult to sleep. Perhaps you have difficulty getting to sleep or perhaps you fall asleep exhausted and then wake up in the night in a panic. As a result, you're likely to feel fatigued a great deal of the time. Living with high levels of panic and anxiety, it's understandable that you will turn to whatever you may feel is likely to decrease your stress. You may use drugs, alcohol, food, or some other distraction to relieve your sense of panic, dread, and depression. However, this will serve only to create a downward spiral making you more impulsive and self-defeating.

Concentration or Memory Problems

You may find it difficult to concentrate on anything. Much of the time, your mind seems to wander, and it's hard to focus. You may be quite inefficient, unable to get things done, even when there is an urgency to do so. It is also hard for you to recall things, so you may worry that there is something wrong with your mind because your memory is not functioning right. Anxiety, worry, and tension all affect memory.

Weakness, Fatigue, Somatic Symptoms

You may complain of weakness, fatigue, tingling in the extremities, dizziness, and other physical symptoms that reflect how tense you are. These physical symptoms may frighten you, and you may seek out medical help for them. They are likely aggravated by anxiety and stress.

Ruminations or Obsessions

You may find yourself thinking, analyzing, and ruminating about some issue that is frightening to you—perhaps you are preoccupied with your relationships and worried you will be criticized, controlled, or abandoned. Even when you try to focus on other things, you may find your mind drifting back and obsessing about some recent setback, loss, or potential abandonment.

Impulsive

You may do things impulsively, following the rushes of emotion and jumping into action before you think things through. In the same way, you may experience surges of sadness and fears of loss, and then you may have impulses to do something desperate or self-destructive. You might walk out on a relationship, punish somebody who has hurt you, or even consider hurting yourself. Working on managing your impulses will be a big part of your treatment program.

Suicidal Ideation

As stress builds, especially if you feel you've made mistakes or if you feel someone is going to leave you, you might find yourself fantasizing about suicide as a way of escaping or even to punish someone. Especially if you drink or use drugs, you might impulsively want to end your life as a way of getting away from the anxiety and depression.

Lifestyle and Background Feedback

People with your profile often grew up in environments where a parent was very supportive and nurturing but also controlling, rejecting, and sometimes unreliable. Perhaps as a child, you were sensitive and experienced periods of anxiety and sometimes panic. You may have felt abandoned and alone. Your parents may have saved you when you got into trouble but then became frustrated with you and treated you in ways that left you feeling rejected. Now, you go through life wanting reassurance, asking people for emotional support, and worrying that you're going to be abandoned. It is understandable that you now experience strong mixed feelings in your close relationships. When somebody loves you and wants your commitment you might become fearful of being controlled or let down. When you get close to someone, you may push them away, anticipating abandonment, and, even when you get reassurance, you worry that it is only because you "demanded it."

Normal-Range Feedback (T-Score 50 to 65)

Your profile is in the normal range. It does tell us, however, that you are experiencing mild anxiety and worry. You have strong needs for affection, but you also fear being controlled. You may gravitate toward relationships with

strong, affectionate people, but then feel controlled and suffocated by their demands on you. You may find yourself telling white lies or being evasive with people because you are afraid to stand up to them for fear of losing their love and support; at the same time you resent feeling controlled.

Experiencing mixed feelings as you do can create physical stress and symptoms such as headaches, stomach upsets, sleep problems, and difficulty with memory and concentration. You are a thoughtful, responsible person, and you take life seriously; however, when stressed you become anxious and overloaded and sometimes make impulsive decisions to relieve stress. Often people with your profile grew up with unreliable parents, which led to a great deal of uncertainty. You may have felt your needs were rarely met because your parents were sometimes uninvolved, sometimes nurturing, but at other times too controlling. No wonder you crave love and support but fear it will lead to control and eventual letdown.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Code-Type 2-4-8

Descriptors

Complaints

Depression, weakness and fatigability, exhaustion, resignation, anhedonia, alienation, disconnection, feeling empty, family or marital problems, sexual difficulties, distrust

Thoughts

Suspicious of others, afraid of emotional involvement, paranoia, resentment, escape into fantasy, hopelessness, suicide or self-defeating potential, anxious thoughts

Emotions

Insecure, strong needs for affection, sensitivity to criticism, sensitivity to demands, anger, fear and proneness to panic, inability to express emotions easily

Traits and Behaviors

Keeps people at a distance, manipulative, uses projection as a defense, rationalizes, argumentative, self-destructive, self-punishing, or self-defeating, unpredictable reactions, moody

(Levak, Siegel, Nichols, & Stolberg, 2011)

Therapist's Notes

In the normal to moderate range these profiles reflect mild distrust and alienation. These individuals feel cautious about being vulnerable and keep people at a distance. When elevated, this code type can reflect either a reactive depression or a chronic pattern of marginal emotional and social adjustment. Though the 2-4-8 would predict alienation, anger, and damaged self-esteem, it does not necessarily indicate a personality disorder. A history of acting out, anger, rebelliousness, alienation, and self-destructive and irrational behavior with occasional depressive episodes would suggest 4-8 individuals who have recently experienced a setback or loss. The 2-4-8 as a personality type represents individuals who have in common a profound distrust of people and their motives. These individuals are alienated, feel disconnected, and experience a sense of emptiness or emotional numbness that leaves them

dysphoric most of the time. They go through life with a detached coldness and are afraid to let down their emotional guard. They crave affection and validation but distrust it, even when received. They don't allow themselves to become emotionally involved, numb their vulnerable feelings, and experience a subsequent sense of emptiness. This profile sometimes indicates sociopathic traits. Schachter and Latane (1964) found that sociopaths were under-aroused. The emotional numbing associated with sociopathy is thought to involve a complex to which genetics and physiology both contribute (Raine, 2008), but where social factors such as childhood trauma are also involved (Raine & Sanmartin, 2001).

As one would expect from the 2-8 elevations, these individuals sometimes have problems with concentration, memory, and cognitive efficiency. Along with the depression and cognitive impairment of the 2-8 is an emotional shutdown reflected by Scale 4, which augments their difficulty in thinking clearly and making rational decisions. They tend to rationalize their behavior yet often think illogically. While they can exhibit paranoia, this tends to be diffuse rather than fixed and rational. They experience the world as dangerous and confusing, and although some may exhibit psychotic symptomatology, this tends to be rare. Clients with the 2-4-8 code type are depressed but in a numb, angry, alienated way. They approach the world defensively, anticipating others' cruelty and protecting themselves with a sullen, demanding anger. They expect relationships to be unrewarding, unfair, and cruel, and they feel justified in acting cruelly when they feel threatened. Tender moments and endearing acts tend to leave them feeling cold and aloof, partly reflecting their distrust in positive human interactions and partly reflecting their tendency to emotionally "numb out." They perceive their environment as threatening, which creates a narrow focus with episodic states of alertness followed by emotional numbness. Research suggests a physiological basis for their hypervigilance, possibly related to a continual slow release of adrenaline followed by emotional exhaustion (Roberts, 2009). Their response to perceived threats leads them either to act out impulsively and dangerously or to shut down. They can appear moody, and some may be misdiagnosed as bipolar. The moodiness reflects on oscillation between a numbed-out, emotionally withdrawn, depressive state reflected in the 2-8 part of the code type, and occasional angry, impulsive, and destructive acts represented by the Scale 4. Sometimes damaging behavior is occasioned by what the 2-4-8 perceives to be as hurtful and vindictive behavior by others. In other cases, impulsive acting out can serve as a temporary "adrenaline rush" for someone who genuinely feels emotionally empty and disconnected. Accordingly, when the 2-4-8 acts out, it is often in bizarre and even incomprehensible ways. Given their fear of emotional closeness and their difficulties modulating their emotions in response to interpersonal connection, it is not surprising that they have many sexual difficulties and, although often preoccupied with sex, they tend to confuse sexuality and aggression.

The 2-4-8 individuals are very sensitive to any demands being placed on them. Notwithstanding their distrust of emotional closeness, clients with this profile tend to be quite demanding of attention and, at the same time, resent

the control involved in the ordinary give-and-take of relationships. This is one of the most divorce- and discord-prone of all profiles. They tend to be chronically resentful and have difficulty expressing emotions in any modulated way. Unpredictable, hard to relate to, easily irritable, and aggrieved, they can be quite hostile when confronted. Their difficulty in achieving connections with others is a reflection of their early childhood emotional abuse and withdrawal. Part of emotional maturity and health is the ability to differentiate complex and interwoven feelings so that they can be verbalized and processed. People with the 2-4-8 profile experience emotional life as amorphous and inchoate. They have very low self-esteem even when appearing grandiose. They feel damaged, which may be reflected in bizarre and distorted responses on the Rorschach such as hole responses with a minus form quality or a high (above .20) X-% (Weiner & Greene, 2008). The profile may reveal a severe depression with damaged self-esteem, schizophrenic and psychotic thought processes, or antisocial personality disorder. (Levak, Siegel, Nichols, & Stolberg, 2011)

Lifestyle and Family Background

A large proportion of these clients report histories of parental rejection or domination. Throughout their childhood, many were labeled as having behavioral problems, and many had below-average school performance, even with above-average IQs. Often, these individuals were the “black sheep” in the family. Rejection, cruelty, and being unwanted have led the child to be angry, rebellious, manipulative, and emotionally numb as a self-protective defense. Studies of unwanted children from Prague who were born to women who had been twice denied abortions revealed these children to be at high risk for poor mental health (David, Dytrych, & Matejcek, 2003). Although acting out can be associated with these code types, sometimes their behavior is more self-defeating and emotionally destructive. Look for histories of sexual, physical, and emotional abuse; neglect; and emotional cruelty. The 2-4-8 profile is characterized by a history of underachievement; teenagers with this profile tend to act out sexually. Suicide threats should be taken seriously as the 2-4-8 can be unpredictably and angrily self-destructive. We hypothesize that numbing withdrawal, paranoid mistrust, and escape into angry fantasy are understandable adaptive responses to histories of rejection, neglect, and cruelty. (Levak, Siegel, Nichols, & Stolberg, 2011)

It may be difficult to determine whether this profile reflects a stable 248 personality style or whether it reflects a 48/84 individual who recently is in trouble because of acting-out behavior, with resulting elevations on Scale 2. In most cases, depression, anxiety, defensive anger, and family and interpersonal problems are present. Acting out tends to be impulsive and angry, and often self-defeating. These individuals feel very distrustful of others. They feel alienated and have difficulty reading how others are feeling. They lack a sense of empathy because they have

withdrawn into a self-protective coldness, keeping others at a distance. Others are likely to judge them as moody and unpredictable. They are quick to feel slighted and can be quick to anger if they feel misunderstood. Sexual difficulties are likely, with sexuality and aggression often mixed. Suicidal ideation and multiple suicide attempts are often present. Distrust is a central characteristic of this profile. It is manifested as a sense of alienation and disconnection from others as well as transitory episodes of diffuse paranoia. These individuals can experience periods of panic, which are manifested through irritable and hostile moods. These are usually precipitated whenever the individual feels vulnerable.

Sometimes this vulnerability occurs when others are being warm and caring, and at the other times, it is when others are being controlling or demanding. Although they verbalize depression, it reflects more a sense of emptiness and disconnection from others than the sense of communicative sadness that is seen in pure depression profiles.

The depression is sensitive to situational changes. These individuals can verbalize feeling anxious, but the anxiety is experienced as diffuse rather than focused, and it reflects their sense of inner emptiness and emotional disconnection from others, as one would expect from the elevation on Scale 8. These individuals are very sensitive to any demands

made on them and can be passively argumentative and resistant, but at the same time are demanding of others.

When frustrated, they can be self-destructive. Parents with this codetype tend to have difficulties parenting their children.

o Like *2-4/4-2* but with much greater general distress, severe alienation from others, fear of emotional involvement, pervasive mistrust, and suicidal ideation. More somatic concern. Moderate to severe depression and pessimism, more anxiety, and greater overall sense of disability. Often unable to maintain employment. Relatively severe impairment of impulse, cognitive, and behavioral controls. More anger, resentment, irritability. Cognitive impairments ranging from forgetfulness and distractibility to intrusive thoughts, hallucinations, and delusions of reference and persecution. Chronically poor judgment. Look for a history of rejection, exploitation, or both; gross behavioral instability with substance abuse, multiple suicide attempts, self-mutilation, and sexual maladjustment. See *2-4/4-2*, *2-8/8-2*, and *4-8/8-4*. *MAC-R* scores may be false negative.

- Persons with this pattern have a high incidence of sexual difficulties (Caldwell, 1972).
- This pattern is found frequently in people with suicidal ideation and multiple suicide attempts (Caldwell, 1985).

Modifying Scales

- When Scale 1 is elevated fourth, numerous vague, bizarre somatic symptoms are present. For example, clients may be preoccupied that they have AIDS, even though they have had limited sexual contact for a long period. Their mistrust will further complicate their relationship with physicians.
- When Scale 3 is elevated fourth, the hysterical repression associated with that scale would aggravate the general confusion and difficulties communicating with the 2-4-8.
- When Scale 6 is elevated fourth, the eruptions of anger can be more dangerous and vindictive, especially if they feel threatened. The diffuse paranoia associated with 2-4-8 profiles would be more focused in such cases.
- Scale 7 elevations would predict more anxiety, self-doubt, and anxious preoccupations. These clients may show more mood swings with periods of hyperanxiety followed by periods of numb, distant, angry acting out.
- When Bizarre Mentation (BIZ), Aberrant Experiences (RC8), and Psychoticism (PSYC) are elevated, look for breakdowns in reality testing.
- When Antisocial Practices (ASP) and/or Antisocial Behavior (RC4) are elevated with one or more of the Psychoticism Scales (above), the potential for dangerous, bizarre, acting-out behavior increases.
- Typically, all of the Harris-Lingoes subscales associated with depression and Scale 8 are elevated in the 2-4-8 profile. The Harris and Lingoes subscales would confirm whether the profile is primarily a depression profile in individuals with profoundly damaged self-esteem or individuals with a personality disorder who are experiencing a reactive depression.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Male

Low 0 Introverted or self-conscious or socially insecure (28), lacks skills with the opposite sex, father conflict, lacks knowledge or information, aggressive or belligerent.

- Note: Both Scale 4 coded high and Scale coded low were infrequently associated with lack of skills with the opposite sex; Scale coded low was infrequently associated with introversion or selfconsciousness or social insecurity.

Low 1/3/5/6/ Introverted or self-conscious or socially insecure, lacks skills with the 7 opposite sex.

- Note: Scale 4 coded high was infrequently associated with lack of skills with the opposite sex.

Low 9 Introverted or self-conscious or socially insecure, lacks skills with the opposite sex.

- Note: Scale 4 coded high was infrequently associated with lack of skills with the opposite sex.

Nothing Low Introverted or self-conscious or socially insecure, lacks skills with the opposite sex, tense, indecisive, unhappy, worries a great deal, insomnia, confused.

- Note: Scale 4 coded high was infrequently associated with lack of skills with the opposite sex.

Female

Low 0 Anxieties, depressed, insomnia, indecisive, distractible in study, lacks academic drive, tense on examinations, lacks skills with the opposite sex, socially extroverted, father conflict, overprotective mother, verbal.

- Note: Scale coded low was infrequently associated with depression and lack of skills with the opposite sex.

Low 1 Anxieties, depressed, insomnia, lacks self-confidence, indecisive, physical inferiority, distractible in study, lacks skills with the opposite sex, socially extroverted, father conflict, overprotective mother.

Low 3 Anxieties, depressed, insomnia, indecisive, distractible in study, lacks skills with the opposite sex, father conflict, overprotective mother.

Low 5 Anxieties, depressed, nervous, insomnia, indecisive, distractible in study, tense on examinations, lacks skills with the opposite sex, socially shy, socially insecure, father conflict, mother conflict, rebellious toward home, overprotective mother, wants answers.

Low 6 Anxieties, depressed, insomnia, indecisive, lacks self-confidence, distractible in study, vague goals, lacks skills with the opposite sex, socially insecure, father conflict, overprotective mother, nonverbal.

Low 7 Anxieties, depressed, insomnia, indecisive, distractible in study, lacks skills with the opposite sex, father conflict, overprotective mother.

Low 9 Anxieties, depressed, insomnia, indecisive, distractible in study, lacks skills with the opposite sex, father conflict, mother conflict, overprotective mother.

Nothing Low Anxieties, depressed, headaches, insomnia, indecisive, distractible in study, lacks skills with the opposite sex, father conflict, mother conflict, sibling conflict, overprotective mother, 8+ conferences.

(Drake & Oetting, 1959)

TREATMENT

Suicide attempts are common with this codetype and often occur in moments of angry desperation. They put the therapist through trust tests, reflecting their fears of emotional abandonment and rejection. Often, childhood histories of rejection, abandonment, and cold cruelty are common. Identity-damaging blows to their self-esteem may have led

them to protect themselves from further hurt by keeping others at a distance. They often become involved in relationships that replicate their childhoods and are abusive or rejecting of their partners. Paternal relations were often indifferent and maternal relations were often rejecting. Early school achievement was often below average.

Interestingly, in the Marks et al. (1974) study, in spite of parental rejection or indifference, 35 percent of the 482 criterion group participants received sex instruction from a family member, the highest proportion of any codetype. The 248 codetype predicts sexual difficulties with sexual aggression confusion, early childhoods of rejection (save for sexual education), and suggests poor boundaries in the family of origin. Supportive, esteem-building psychotherapies, rather than insight-oriented ones, are most useful. These individuals can become cognitively disorganized by insight therapy.

They respond well to boundaries set by the therapist. Practical, goal-directed, supportive psychotherapies that help rebuild their self-esteem and develop coping skills are often effective. Help them recognize when impulse pressures are building so that they do not act out in self-defeating ways. Brief psychotic episodes can occur in some individuals, especially if they abuse chemical agents.

The codetype is associated with chemical addiction proneness. Avoid group psychotherapy until a trusting relationship with the primary therapist is developed. In the presence of severe depression, a sedating antidepressant may be useful.

Therapy and Therapeutic Pitfalls

Therapy tends to be difficult with 2-4-8 individuals because of their basic mistrust. Therapists often have difficulty empathizing with individuals who themselves lack empathy. Moreover, the clients' anger and emotional disconnection from the therapist make therapy challenging. These clients tend to see others as wearing a mask and feel as though they are unable to "read" others' responses to them, so they are afraid to reveal their own vulnerabilities. They anticipate rejection and criticism due to their own childhood conditioning experiences of cruelty and emotional abandonment. They feel unlovable and damaged, and they push others away in anticipation of being rejected. Supportive, nurturing therapies that hold clients accountable without anger are most effective.

Obtaining information from family members is helpful because people with 2-4-8 profiles tend to selectively report as part of their belief that manipulation is the only way to get their needs met. Often, the 2-4-8 depression is in response to some emotional setback, and when the situation is alleviated they often terminate therapy. The clients will replicate their relationship with a cold parent by attempting to avoid vulnerability with the therapist, so testing the therapist will be an ongoing dynamic. Helping clients develop empathy for themselves as a frightened and abandoned child can be useful once they feel able to trust. Educate them about how they shut off their emotions to protect themselves. During the course of therapy, observe any moments when they experience an emotional response, alert them to their tendency to switch it off and, using relaxation exercises, teach them to "switch back on" a state of emotional connectedness. Help them to anticipate stress and to rehearse nonaggressive responses. Schema therapy (Arntz, Genderen, Drost, Sendt, & Baumgarten-Kustner, 2009), assertiveness training (Hayakawa, 2009),

and dialectical-behavioral therapy (Linehan, 2000) have been quite effective in teaching similar clients to label feelings appropriately and manage their relationships more effectively. Female clients expect male therapists to be exploitive; be careful of subtle, if not overt, seductiveness. It is important to be empathic while offering an alternative perspective: for example, explain that powerful feelings often come up during the course of therapy (Gabbard & Horowitz, 2009). The therapist should be mindful and open to the transference and countertransference while remaining stable, predictable, and staying in a neutral, therapeutic role without being too rigid (Kernberg, Selzer, Koenigsberg, Carr, & Appelbaum, 1989). Suicide threats should be taken seriously, as people with a 2-4-8 profile can be unpredictably and angrily self-destructive. (Levak, Siegel, Nichols, & Stolberg, 2011)

Treatment and Self-Help Suggestions

1. Work with your therapist to see if you can identify any “schemas” or themes that you developed in dealing with childhood experiences.¹ Some common themes include the expectation you will lose anyone you get attached to, the belief that others will take advantage of you, or the belief that others will somehow hurt you or put you down. Work with your therapist in session to imagine a conversation with the person that feeling involves. Being able to express the emotions in the safety of the therapy setting can gradually help you to learn new perspectives and challenge these old schemas.²
2. Learning various types of intentional relaxation can help calm your automatic reactions to stressful situations. One type of relaxation, diaphragmatic breathing, exerts a powerful effect on your physical response to stress. When you feel threatened, your breathing is rapid and shallow, but this exercise can calm the automatic response of your nervous system and reduce reactive thinking and destructive emotions. Work with your therapist to learn diaphragmatic breathing; practice two times each day, and then continue to practice on a regular basis.³
3. Notice when you want to escape or avoid an emotional situation that makes you anxious or uncomfortable. This is often the result of early experiences where you were told that what you were feeling was “wrong.” This type of escape or avoidance will actually make you feel worse in the long run because you feel less competent and less hopeful that you can change the situation. See if you can identify situations in your childhood where you felt strong feelings but were told that they were wrong.
4. Notice when you have strong emotions that are followed by a sense of shame or a feeling that someone else is to blame. See if you can begin looking at feelings without attaching judgment to them; instead, see them as pieces of information about your world, clues about how to solve life’s problems. For example, if you are angry with your boss, instead of blaming yourself or feeling “bad” see if you can gather any clues about why you are angry; perhaps you’re uncomfortable with a new task and need to ask for more training.

5. Mindfulness is a way to begin to manage your emotional responses. Mindfulness involves paying attention to the present moment in a nonjudgmental way and fostering a quality of curiosity and openness.⁴ For more information on mindfulness exercises see www.mindfulnessstapes.com. You can begin by setting aside time to watch the moment without analyzing or judging it. Pay attention to the sight, sound, taste, smell, and feel of the experience. Engaging in the daily practice of mindfulness can help you manage powerful emotions.⁵

6. Assertive persons are able to stand up for themselves, to express their feelings honestly, and to be direct and confident. Be aware of your body language: stand straight, make eye contact, and speak clearly. Point out the behavior you find unacceptable, and make a specific request: "I get sidetracked when you interrupt me; please let me finish my train of thought." There are many good books on assertiveness, such as *When I Say No, I Feel Guilty* (Smith, 1975).

¹ Schema therapy has been demonstrated to be an effective treatment for clients who expect and anticipate emotional rejection and criticism based on their own early childhood conditioning experiences.

Help clients first identify their particular schema (Bricker & Young, 2004), and then work to help them examine the early experiences that led to that belief. The next step is to challenge that idea and help them examine whether it is true and whether it is helpful (Young, Klosko, & Weishaar, 2003).

² Schema therapy uses many of the same methods of CBT but adds imagery to uncover suppressed emotions and to highlight the ways that these fixed beliefs affect current relationships (Young, 1999).

³ When engaging in relaxation exercises, the parasympathetic nervous system (PNS) is activated, which slows heart rate, breathing, and blood pressure. When the PNS is activated, the body enters a restorative mode that counteracts the effects of stress (Roberts, 2009).

⁴ Bishop et al. (2004) explain mindfulness as an acceptance of the present moment and a playful and curious awareness.

⁵ Mindfulness and compassion can play a powerful role in helping people who have traumatic backgrounds and perceive threats either from the external world (what others might do to them) or from their internal feelings of being overwhelmed by self-contempt or troubling memories (Gilbert & Tirsch, 2009). Orzech, Shapiro, Brown, and McKay (2009) studied the role of intensive mindfulness training on changes in psychological symptoms and found significant increases in well-being, self-compassion, and resilience and decreases in anxiety after 1 month of mindfulness training.

(Levak, Siegel, Nichols, & Stolberg, 2011)

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you are experiencing periods where you feel sad, blue, and unhappy. Often people with your profile grow up in environments where you could not count on your caretakers for emotional support. Perhaps

one or both of your parents were cold or rejecting, so from an early age you had to protect yourself by not letting yourself care too much. You may have even experienced periods where someone was cruel, so that you learned to protect yourself by not letting people get close. Now, when you get involved with others, you may find yourself overwhelmed by anger or mood swings and not know why. If someone is warm or kind to you, you might get angry, as if you're afraid that by letting them in you become too vulnerable to getting hurt. At other times you may become preoccupied with how someone has hurt you, and you may dwell on fantasies of how to deal with them and punish them. It may be hard for you to express yourself and to share with others what you are feeling in a way that feels satisfying. At times you may experience intense anxiety, as if the world is crumbling and you do not know whom to trust. This is because from an early age you had to learn to protect yourself, to keep a wall up around you so that you could not be hurt. You may find it difficult to open up and let people get close to you because of early childhood experiences. The therapist may want to suggest medicine to take away some of the sadness and help you sleep and feel more rested. Rehearse with your therapist what you can do when you feel stressed so that you do not act in impulsive ways that later make you feel bad about yourself. When you feel close to someone, watch your tendency to be angry and push them away, perhaps as a way of protecting yourself against getting too involved. Learn to switch off some of your dark fantasies. Learn to recognize what emotions you are feeling so that you can express them in ways that others can accept.

Feedback Statements—Elevated Profiles (T-Score > 65)

Depression

Your profile shows that, currently, you're feeling quite depressed. You may have experienced sad moods and crying spells and have difficulty concentrating, remembering things, and getting things done. You may have eating problems, weight changes, and periods of sad, negative, and despondent moods.

Distrust

A big problem for you is learning to trust people. You're going through life keeping a distance from others, as if you are trying to protect yourself from anyone hurting you or being cruel to you. You may find yourself ready to argue and to confront people too readily, perhaps because you expect to be let down, humiliated, and treated cruelly.

Alienation, Disconnection, Emptiness

Your profile suggests that you're feeling very disconnected and alienated from other people. It's hard for you to let your guard down and let people get close, and you don't take emotional risks and reach out to people. You may have

few people to whom you can turn, so you feel a sense of deep aloneness and emptiness. Although your profile shows you feel depressed, sometimes you may experience an empty “deadness,” where you feel no emotions at all. This can be very uncomfortable and hard to describe to others.

Family, Marital, or Sexual Problems

Your profile suggests that it's very difficult for you to trust people and that you are on guard to protect yourself from being hurt and let down. Therefore, you may have family or marital problems and conflict with people close to you. That probably makes it hard for you to really enjoy sex because you don't experience a sense of closeness easily. Sometimes mixing sex and violence or cruelty might seem desirable as a way of getting sexual relief while keeping emotional intimacy at bay.

Paranoia

At times, you may feel a vague and highly uncomfortable sense of paranoia, as if the world is an unpredictable and scary place. Because it's hard to trust anyone, you're never quite sure whether you're reading people the right way. You may find yourself wondering about people's motives, and when stressed you might take things so personally that you think people are out to harm you in some way. At these times, you may fantasize about how to protect yourself by being cruel to them first.

Suicide or Self-Defeating Potential

Sometimes you may feel so bad and so trapped that you think about just giving up and killing yourself. You may even fantasize about it, partly as a way of escaping and partly as a means of punishing others. It would be important to talk to your doctor if you feel that alone and defeated.

Angry or Moody

You may find yourself often feeling a sense of anger and rage without always knowing where it's coming from. People with your profile are often seen as moody. You may be irritable, gloomy, and angry without really knowing why. Even when things are going well, you may find yourself wanting to initiate conflicts with others. You may be getting along with someone, even liking someone, and suddenly you find yourself disliking or hating the person for no obvious reason. You will learn in therapy that these shifting and odd moods may be the result of events that happened in your childhood where you could never trust or feel safe in the emotional climate created by the others around you.

Keep People at a Distance

You tend to keep people at an emotional distance to protect yourself. You may do that by withdrawing and staying quiet, or you might do it by saying inappropriate and hostile things to them. To protect yourself from being hurt, you may try to keep people off-guard by unpredictably saying things that confuse them.

Manipulative

You're going through life feeling like you have to manipulate people to get what you want. Sometimes you manipulate in a passive way, and sometimes you do it more directly. You can't quite believe that people can really care about one another, so asking for what you want is hard for you. Rather, you feel that you have to manipulate others to get them to do even basic things you deserve.

Unpredictable or Self-Destructive

When tension builds, you may do impulsive and unpredictable things that seem odd to people, and you may be self-destructive and self-punishing. You may break things that are important to you, or you may give up on relationships, even when the other person does not deserve it. You may destroy things out of anger, even if, in the end, you suffer for it. Some of your behavior, which may seem bizarre to others, is your way of expressing all your mixed-up and confused emotions in some symbolic way.

Lifestyle and Background Feedback

People with your profile often grew up in situations where they were treated cruelly by dominating and even abusive parents. It may not have been your parents but some other adult who made you afraid to trust and to be vulnerable. You learned from an early age to numb yourself, to stand back, to observe, and to not let yourself ever care for anyone fully. Someone may have been very controlling of you, so now you are very sensitive to any demands placed on you. It's hard for you to trust anyone, especially someone who is nice to you. You may find yourself gravitating toward relationships where you are treated badly, perhaps because that is what you expect given your childhood. You may confuse sexuality and aggression because of the way you were treated as a child. Explore with your therapist whether you remember specific acts of cruelty directed toward you, and see if you can reengage how that would have felt. See if you can actually remember switching off your emotions, numbing yourself, and feeling that cold sense of distance from the abusive moment.

Normal-Range Feedback (T-score 50 to 65)

Your profile is in the normal range. It shows you to be a cautious, analytical person who is quite sensitive to being let down or mistreated by others. You may desire affection and attention from others, but you are also cautious about others exploiting your vulnerabilities. You may want to get along with people but find yourself unable to express affection and sustain feelings of warmth easily. You may find yourself standing back and observing, often rationalizing reasons why you should maintain some protective distance. You probably find people unpredictable and difficult to trust. You may have opened up to people and have felt taken advantage of, so you don't develop trust in your relationships easily. You can appear argumentative and resentful, especially when you become frustrated with people. When things don't go well you tend to respond impulsively and unpredictably, which pushes people farther away from you.

(Levak, Siegel, Nichols, & Stolberg, 2011)

249/429 Code

o Like 2-4 but with greater self-centeredness, immaturity, and problems in impulse control. Look for substance abuse, instability of employment, and a history of legal difficulties.

Male

Low 0 Father conflict, tense on examinations, aggressive or belligerent, rationalizes a great deal. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, shyness in the interview, being nonresponsive or nonverbal, being nonverbal or a nonrelator, indecisiveness.

Low 1/3/5/6/7/8 Tense on examinations, aggressive or belligerent, rationalizes a great deal.

Nothing Low Introverted or self-conscious or socially insecure, lacks skills with the opposite sex, tense, tense on examinations, unhappy, worries a great deal, insomnia, aggressive or belligerent, rationalizes a great deal.

- Note: Scales 4 and 9 coded high were infrequently associated with lack of skills with the opposite sex; Scale 9 was infrequently associated with worrying a great deal.

Female

Low 0 Anxieties, depressed, indecisive, lacks self-confidence, lacks skills with the opposite sex, socially insecure (29), socially extroverted (49, 4-0, 9-0, 49-0) , father conflict, home conflict, tense on examinations, lacks academic drive, marriage oriented, vague goals, verbal.

- Note: Scale coded low was infrequently associated with depression, lack of self-confidence, lack of skills with the opposite sex, social insecurity, home conflict.

Low 1 Anxieties, depressed, indecisive, lacks self-confidence, physical inferiority, lacks skills with the opposite sex, socially insecure (29), socially extroverted (49, 4-1, 9-1, 49-1), father conflict, home conflict, vague goals, verbal.

Low 3 Anxieties, depressed, indecisive, lacks self-confidence, lacks skills with the opposite sex, socially insecure (29), socially extroverted (49), father conflict, home conflict, vague goals, verbal.

Low 5 Anxieties, depressed, nervous, exhaustion, indecisive, lacks self-confidence, lacks skills with the opposite sex, socially insecure (29, 2-5), socially shy (2-5), socially extroverted (49), father conflict, mother conflict, home conflict, rebellious toward home, vague goals, tense on examinations, verbal, wants answers.

Low 6 Anxieties, depressed, indecisive, lacks self-confidence, lacks skills with the opposite sex, socially insecure (29, 2-6), socially extroverted (49), father conflict, home conflict, vague goals, verbal (49) , nonverbal (2-6)

Low 7/8 Anxieties, depressed, indecisive, lacks self-confidence, lacks skills with the opposite sex, socially insecure (29), socially extroverted (49), father conflict, home conflict, vague goals, verbal.

Nothing Low Anxieties, depressed, indecisive, lacks self-confidence, lacks skills with the opposite sex, socially insecure (29), socially extroverted (49), father conflict, home conflict, vague goals, verbal.

(Drake & Oetting, 1959)

2489 Code

Women with this pattern may have many affairs with men, but typically do not enjoy them (Caldwell, 1972).

25/52 Codes

(see also 275/725 Codes if Scale 7 is Within Five T-Score Points of Scale 5)

Men with this code are idealistic, inner-directed, unassertive, indecisive, and depressed. They care deeply about others and have a philosophical perspective. They worry about the cruelty of world events. They dislike competitiveness and at times can be passive. Acting out is unlikely and conflict tends to be handled verbally, intellectually, and with reasonableness and rationality. They are psychologically-minded and want to discuss their feelings. They are sensitive, easily hurt and can exhibit anxiety and, at times, withdraw. Some may complain of somatic symptoms and may exhibit some of the symptoms of depression, such as sleep difficulties, problems with concentration and memory, and low energy. They can be self-aware to the point of being painfully selfconscious. They are fussy and can be self-critical. Sexual adjustment may be impaired, perhaps because of their low self-esteem, sensitivity, and tendency to passivity. This is a rare codetype among women. The high Scale 5 suggests a woman who has traditionally masculine interests and is comfortable in the world of men. She presents

as depressed, inwardly focused, prone to feeling guilty, and duty-oriented. An example of a 25 woman might be somebody who enjoys outdoor activities, perhaps living and working on a farm, or perhaps a research scientist or someone who is comfortable in a practical, competitive, action-oriented, traditionally male world, such as the military.

At the same time, she is circumspect and prone to periods of withdrawal and negative thinking. She is also analytical and careful to avoid attention.

Male adolescents (e.g. 18–19 years of age) with this codetype exhibit problems in their social relationships because of their sensitivity and shyness. Often interpersonally unassertive, they tend to over-intellectualize and to be perfectionistic and meticulous. Sometimes, because of stereotypes about traditional male behavior, they can be teased by their peers and called “gay” even though they may have a heterosexual orientation.

o Look for chronic anxiety or depression (men) or depression (women); problems with passivity, dependency, anergia, conflict in close relationships, resentment of demands and responsibilities, and poor sexual adjustment. Cognitive slowing. Identity may be confused or diffuse. History of or current polydrug abuse and mood disorder. Check third highest scale.

- Adolescents in treatment with the 2-5/5-2 pattern (Marks et al., 1974) were referred because of poor relationships with their siblings. They tended to be indecisive, shy, hypersensitive, suspicious, and negative. They were seen as unmasculine and rarely dated. They also had anti-social activities such as breaking and entering and stealing. The Marks, Seeman, and Haller book should be consulted for further information concerning this profile.
- College students with this profile combination are usually anxious and have a history of physical complaints and difficulties. They also have a history of dating infrequently (King & Kelley, 1977b).

Male

Low 0 Wants reassurance only, worries a great deal.

- Note: Scale coded low was infrequently associated with worrying a great deal. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, lack of skills with the opposite sex, being nonresponsive or nonverbal, tension.

Low 1 Wants reassurance only, worries a great deal, restless.

Low 3/4/6/7/8/9 Wants reassurance only, worries a great deal.

Nothing Low Introverted or self-conscious or socially insecure, lacks skills with the opposite sex, home conflict, wants reassurance only, tense, unhappy, worries a great deal, insomnia.

- Note: Scale 5 coded high was infrequently associated with tension.

Female

Low 0 Socially extroverted, tense on examinations.

Low 1 Lacks self-confidence, physical inferiority.

Low 4 Lacks self-confidence.

Low 6 Lacks self-confidence, socially insecure, nonverbal.

Low 9 Mother conflict.

Nothing Low Depressed, distractible in study, lacks skills with the opposite sex.

- Note: Scale 5 coded high was infrequently associated with depression.

(Drake & Oetting, 1959)

Description:

Women: lower SES, interpersonal and social role conflict;

Men: passive, noncompetitive, sensitive, idealistic, use fantasy, may have mild depression

Possible Diagnoses:

Passive-aggressive pers. dis., Dependent pers. dis.

TREATMENT

Standard depression treatment such as CBT would be effective with this codetype. In some areas of the country homosexuality may still be judged negatively, so explore any issues that may be associated with this. Assertiveness training and coaching for men on how to relate intimately may be helpful. Look for childhood experiences of an opposite gender parent identification and deficits of age-appropriate childhood carefreeness. Explore the possibility of homosexual awareness from an early age and its possible resulting internal conflicts.

THERAPEUTIC FEEDBACK LANGUAGE

Your profile shows that you are a person who is dutiful, responsible, and prone to worry. For men: You are a sensitive individual who cares about how others feel and you are prone to worry about the world and how people treat one another. You are sensitive to how things look and feel and you do not focus on just the practical aspects of life. You care about the mood and aesthetics in any situation and how things look, and you respond positively to

elegance. You tend not to be very assertive. You hang back, observe, analyze, and you tend not to express anger very directly. Others may see you as quite fussy about the way things should be done, and even though you may feel critical of how others do things, it is hard for you to tell people what you think would work best because you do not want to offend them.

Men with your profile are comfortable in the world of women and enjoy what may be seen as traditionally feminine interests and values. Competitiveness, harshness, and traditional male activities are less interesting to you. At times your tendency to hang back and to avoid being pushy may mean that others take advantage of you or are able to bully you into doing things you are not comfortable with. Your profile also suggests that you are somewhat quick to feel guilty and down on yourself. You are not as happy and as positive as you would like to be. Your therapist may want you to try medicine to help you sleep better, feel more rested, and increase your sense of efficiency. At the same time, work at being more assertive and learn to express what you feel more directly. Talk to your therapist about any childhood experiences where you felt you had to be dutiful and responsible, and where you felt fearful that letting down your guard could lead to some kind of loss. Learn to celebrate your accomplishments and watch your tendency to catastrophize.

For women: Your profile also suggests that you have a well-developed practical, action-oriented side, and that you are comfortable in the world of men. When a problem arises, you want to do something, rather than talk about it. No wonder that being around women with traditional feminine interests is less interesting to you than being in a world of action. At the same time, your profile suggests that you are not feeling as happy and positive as you would like. You are a dutiful, responsible, and introspective individual who can feel guilty easily when things go wrong. Your therapist may want to try you on medicine to help you sleep better, feel more rested, and increase your sense of efficiency. At the same time, work at being more assertive and learning to express what you feel more directly. Talk to your therapist about any childhood experiences where you felt you had to be dutiful and responsible, and where you felt fearful that letting down your guard could lead to some kind of loss. Learn to celebrate your accomplishments and watch your tendency to catastrophize.

256 Code

Male

Low 0 Wants reassurance only, worries a great deal.

- Note: Scale coded low was infrequently associated with worrying a great deal. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, lack of skills with the opposite sex, being nonresponsive or nonverbal, tension.

Low 1 Wants reassurance only, worries a great deal, restless.

Low 3/4/7/8/9 Wants reassurance only, worries a great deal.

Nothing Low Introverted or self-conscious or socially insecure, lacks skills with the opposite sex, home conflict, wants reassurance only, tense, unhappy, worries a great deal, insomnia.

- Note: Scale 5 coded high was infrequently associated with tension.

Female

Low 0 Anxieties, 8+ conferences, resistant in the interview, socially extroverted, tense on examinations.

- Note: Scale 5 coded high was infrequently associated with anxieties and 8+ conferences.

Low 1 Anxieties, 8-|- conferences, lacks self-confidence, physical inferiority.

- Note: Scale 5 coded high was infrequently associated with anxieties and 8+ conferences.

Low 3 Anxieties, 8+ conferences.

- Note: Scale 5 coded high was infrequently associated with anxieties and 8-|- conferences.

Low 4 Anxieties, 8+ conferences, shy in the interview, lacks self-confidence.

- Note: Scale 5 coded high was infrequently associated with anxieties and 8+ conferences.

Low 7/8 Anxieties, 8+ conferences.

- Note: Scale 5 coded high was infrequently associated with anxieties and 8+ conferences.

Low 9 Anxieties, 8+ conferences, mother conflict.

- Note: Scale 5 coded high was infrequently associated with anxieties and 8+ conferences.

Nothing Low Anxieties, restless, depressed, 8+ conferences, lacks skills with the opposite sex, distractible in study.

- Note: Scale 5 coded high was infrequently associated with anxieties and 8-|- conferences.

257 Code

Male

Low 0 Home conflict, one interview only, wants reassurance only, tense (27), tense on examinations, indecisive, unhappy, worries a great deal, lacks knowledge or information.

- Note: Scale coded low was infrequently associated with indecisiveness, unhappiness, and worrying a great deal. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, lack of skills with the opposite sex, being nonresponsive or nonverbal, tension (5-0),

Low 1 Home conflict, wants reassurance only, nonresponsive or nonverbal, restless, tense, tense on examinations, indecisive, unhappy, worries a great deal, confused.

- Note: Scale 5 coded high was infrequently associated with tension.

Low 3/4/6/8/9 Home conflict, wants reassurance only, tense, tense on examinations, indecisive, unhappy, worries a great deal.

- Note: Scale 5 coded high was infrequently associated with tension.

Nothing Low Introverted or self-conscious or socially insecure, lacks social skills, lacks skills with the opposite sex, home conflict, mother conflict, sibling conflict, wants reassurance only, nonresponsive or nonverbal, tense, tense on examinations, indecisive, unhappy, worries a great deal, insomnia, confused.

- Note: Scale 5 coded high was infrequently associated with tension.

Female

Low 0 Anxieties, depressed, lacks self-confidence, socially shy (27), socially insecure (27), socially extroverted (5-0), distractible in study, tense on examinations, 4 to 7 conferences.

- Note: Scale 5 coded high was infrequently associated with anxieties, depression, social shyness; Scale 0 coded low was infrequently associated with social shyness and social insecurity.

Low 1 Anxieties, depressed, lacks self-confidence, physical inferiority, socially shy, socially insecure, distractible in study, 4 to 7 conferences.

- Note: Scale 5 coded high was infrequently associated with anxieties, depression, social shyness.

Low 3 Anxieties, depressed, lacks self-confidence, socially shy, socially insecure, distractible in study, 4 to 7 conferences, cried in the interview.

- Note: Scale 5 coded high was infrequently associated with anxieties, depression, social shyness.

Low 4 Anxieties, depressed, lacks self-confidence, socially shy, socially insecure, distractible in study, 4 to 7 conferences.

- Note: Scale 5 coded high was infrequently associated with anxieties, depression, social shyness.

Low 6 Anxieties, depressed, lacks self-confidence, socially shy, socially insecure, distractible in study, 4 to 7 conferences, nonverbal.

- Note: Scale 5 coded high was infrequently associated with anxieties, depression, social shyness.

Low 8 Anxieties, depressed, lacks self-confidence, socially shy, socially insecure, distractible in study, 4 to 7 conferences.

- Note: Scale 5 coded high was infrequently associated with anxieties, depression, social shyness.

Low 9 Anxieties, depressed, lacks self-confidence, socially shy, socially insecure, distractible in study, 4 to 7 conferences, mother conflict.

- Note: Scale 5 coded high was infrequently associated with anxieties, depression, social shyness.

Nothing Low Anxieties, depressed, headaches, lacks self-confidence, socially shy, socially insecure, lacks skills with the opposite sex, distractible in study, 4 to 7 conferences, sibling conflict.

- Note: Scale 5 coded high was infrequently associated with headaches, anxieties, depression, social shyness. (Drake & Oetting, 1959)

258 Codes

o Passivity, apathy, dysphoria or depression, and anhedonia. Sexual maladjustment and sexual identity concerns may be severe.

Male

Low 0 Introverted or self-conscious or socially insecure (28), lacks skills with the opposite sex (28), home conflict, wants reassurance only, worries a great deal, lacks knowledge or information, aggressive or belligerent.

- Note: Scale coded low was infrequently associated with lack of skills with the opposite sex and worrying a great deal. This pattern was infrequently associated with introversion or self-consciousness or social insecurity (5-0), lack of skills with the opposite sex (5-0), being nonresponsive or nonverbal, tension.

Low 1 Introverted or self-conscious or socially insecure, lacks skills with the opposite sex, home conflict, wants reassurance only, restless, worries a great deal.

Low 3/4/6/7 Introverted or self-conscious or socially insecure, lacks skills with the opposite sex, home conflict, worries a great deal, wants reassurance only.

Low 9 Introverted or self-conscious or socially insecure, lacks skills with the opposite sex, home conflict, worries a great deal, wants reassurance only.

Nothing Low Introverted or self-conscious or socially insecure, lacks skills with the opposite sex, home conflict, wants reassurance only, tense, indecisive, unhappy, worries a great deal, insomnia, confused.

- Note: Scale 5 coded high was infrequently associated with tension.

Female

Low 0 Anxieties, depressed, distractible in study, tense on examinations, lacks skills with the opposite sex, socially extroverted, verbal.

- Note: Scale coded low was infrequently associated with depression and lack of skills with the opposite sex; Scale 5 coded high was infrequently associated with anxieties, depression, social shyness.

Low 1 Anxieties, depressed, distractible in study, lacks skills with the opposite sex, lacks self-confidence, physical inferiority.

- Note : Scale 5 coded high was infrequently associated with anxieties, depression, social shyness.

Low 3 Anxieties, depressed, distractible in study, lacks skills with the opposite sex.

- Note: Scale 5 coded high was infrequently associated with anxieties, depression, social shyness.

Low 4 Anxieties, depressed, distractible in study, lacks skills with the opposite sex, lacks self-confidence.

- Note: Scale 5 coded high was infrequently associated with anxieties, depression, social shyness.

Low 6 Anxieties, depressed, distractible in study, lacks skills with the opposite sex, socially insecure, lacks self-confidence, nonverbal.

- Note: Scale 5 coded high was infrequently associated with anxieties, depression, social shyness.

Low 7 Anxieties, depressed, distractible in study, lacks skills with the opposite sex.

- Note: Scale 5 coded high was infrequently associated with anxieties, depression, social shyness.

Low 9 Anxieties, depressed, distractible in study, lacks skills with the opposite sex, mother conflict.

- Note: Scale 5 coded high was infrequently associated with anxieties, depression, social shyness.

Nothing Low Anxieties, depressed, distractible in study, lacks skills with the opposite sex, 8+ conferences, father conflict, mother conflict, sibling conflict.

- Note: Scale 5 coded high was infrequently associated with father conflict, 8+ conferences, anxieties, depression.

(Drake & Oetting, 1959)

259 Code

Male

Low 0 Mother conflict, wants reassurance only, tense on examinations, worries a great deal, poor rapport, aggressive or belligerent, rationalizes a great deal.

- Note: Scale coded low was infrequently associated with poor rapport and worrying a great deal. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, shyness in the interview, lack of skills with the opposite sex, being nonresponsive or nonverbal, being nonverbal or a nonrelator, tension, indecisiveness.

Low 1 Mother conflict, wants reassurance only, restless, tense on examinations, worries a great deal, poor rapport, aggressive or belligerent, rationalizes a great deal.

- Note : Scale 9 coded high was infrequently associated with worrying a great deal.

Low 3/4/6/7/8 Mother conflict, wants reassurance only, tense on examinations, worries a great deal, poor rapport, aggressive or belligerent, rationalizes a great deal.

- Note: Scale 9 coded high was infrequently associated with worrying a great deal.

Nothing Low Introverted or self-conscious or socially insecure, lacks skills with the opposite sex, home conflict, mother conflict, wants reassurance only, tense, tense on examinations, unhappy, worries a great deal, insomnia, poor rapport, aggressive or belligerent, rationalizes a great deal.

- Note: Scale 9 coded high was infrequently associated with lack of skills with the opposite sex and worrying a great deal; Scale 5 coded high was infrequently associated with tension.

Female

Low 0 Vague goals, tense on examinations, marriage oriented, lacks self-confidence, socially insecure (29), socially extroverted (59, 9-0, 5-0, 59-0), verbal.

- Note: Scale coded low was infrequently associated with social insecurity and lack of self-confidence.

Low 1 Vague goals, lacks self-confidence, physical inferiority, socially insecure (29), socially extroverted (59, 9-1).

Low 3 Vague goals, lacks self-confidence, socially insecure (29), socially extroverted (59).

Low 4 Vague goals, lacks self-confidence, socially insecure (29), socially extroverted (59), shy in the interview, nonresponsive.

Low 6 Vague goals, lacks self-confidence, socially insecure (29) , socially extroverted (59), nonverbal.

Low 7/8 Vague goals, lacks self-confidence, socially insecure (29), socially extroverted (59).

Nothing Low Vague goals, distractible in study, lacks self-confidence, socially insecure (29), socially extroverted (59), lacks skills with the opposite sex, depressed.

- Note: Scale 5 coded high was infrequently associated with depression.

Code-Type 2-6/6-2

Descriptors

Complaints

Depression (crying spells, sleep problems, physical symptoms, feeling hopeless, angry, tiredness, weight changes, eating problems), anxiety, anger, resentment, feeling victimized or unfairly treated, feeling inferior

Thoughts

Critical, bitter, resentful, wounded

Emotions

Feeling trapped, feeling hurt, irritable, rationalized resentments

Traits and Behaviors

Rigid values, extreme sensitivity, reaction-formation, withdrawn, inhibition or subassertiveness

(Levak, Siegel, Nichols, & Stolberg, 2011)

Therapist's Notes

2-6/6-2 scores in the average range are indicative of individuals who have high standards and equally high expectations of others. When clinically elevated, this Psychoticism (PSYC) and Aberrant Experiences (RC8) are primarily a depression profile with underlying paranoid features. Rarely is this a psychotic depression, although if Scale 8 is coded third and Bizarre Mentation (BIZ) are also elevated, then the profile could reflect a psychotic depression. In the typical 2-6 profile, the depression is manifested as a hurt, wounded bitterness in which individuals feel unfairly treated and trapped in a current predicament. Their anger is expressed as a feeling of being wounded, resentful, hurt, and mistreated by others, and these clients self-protectively withdraw. The elevation on Scale 6 suggests a tendency to misinterpret others' motives, a quickness to feel hurt and take offense, an inclination to see others' behavior as somehow pointedly hurtful toward them. These clients have difficulty expressing their hurt and anger directly because they are afraid of the criticism and rejection that may follow it. This becomes a self-fulfilling prophecy because their withdrawal, hurt, and resentment incite others to feel angry with them. This confirms the

view of 2-6 individuals that they are being unfairly treated and maliciously attacked. These profiles reflect the typical complaints associated with depression: sad moods, crying spells, somatic preoccupations, tiredness, weight changes, eating difficulties, and sleep disturbance. Feelings of inferiority and anxiety are also typical, however; the elevation of Scale 6 adds resentment and the sense of feeling victimized and unfairly treated. These clients often withdraw, sometimes treating others with long periods of hurt silence. When the 2-6 clients do express anger, it's usually after a long accumulation of stored resentments, which can explode into righteous, self-protective anger. They have poor coping skills because they misinterpret others' motives and are preoccupied with how others are mistreating them. They tend to be critical and judgmental of others, perhaps as a reflection of their own fears of being criticized and judged.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Lifestyle and Family Background

This profile is associated with childhood backgrounds of emotional deprivation and unfair, will-breaking criticisms. We hypothesize that people with 2-6 profiles are responding to what they perceive as unbearable criticism by withdrawing and protectively developing a paranoid sensitivity to anything that can be construed as disapproval. Anticipating criticism, they do not express their wants, desires, or anger but, rather, withdraw into hurt silence until they feel justified in expressing anger, which erupts as a breakdown of brittle control. They don't make demands directly but do so by inducing guilt. Disappointments are expressed as being "hurt," though others feel subtly blamed. When angered and hurt, they are quite unforgiving and will treat others with long periods of silence, reflecting their adaptation in childhood to the futility of arguing their case. Feeling hurt and unfairly treated, they passively express resentment as if anything done for them is too little, too late. They are subtly demanding, but if others try to please them they are fearful that showing gratitude will leave them in debt to others and therefore vulnerable to being controlled. Storing rationalized resentments can be seen as an adaptive attempt to protect against unfair criticisms by accumulating evidence as a defense against future attacks.

(Levak, Siegel, Nichols, & Stolberg, 2011)

This is a depression profile with underlying paranoid features. Individuals with this codetype feel trapped in a current situation, and feel their current depression is due to unfair, insensitive, and callous treatment by others, yet they feel unable to alleviate it. The elevation on Scale 6 predicts touchiness, quickness to feel hurt and take offense, and a tendency to feel victimized and self-righteously angry. These individuals have difficulty expressing resentments directly, perhaps out of fear of retaliation, so they tend to accumulate them. This leads to a self-fulfilling

prophecy, whereby the resentments, when finally expressed, lead others to resenting them, confirming their view that they cannot express their feelings without retaliation.

Typical complaints for individuals with this codetype are sad moods, crying spells, worrying, somatic preoccupations, feelings of inferiority, and difficulties with sleep, concentration, memory, general efficiency, and energy. Others can view this individual as critical and bitter. Feeling trapped in a current predicament, mistreated and victimized and, at the same time, fearful about expressing their emotions, they tend to withdraw into hurt silences that are annoying to others who then judge their behavior as pouting. They misinterpret others' motives and store up and rationalize their resentments. A hypothesis is that they experienced critical and judgmental parents that they could not please. Their response was to "give up trying," but at the same time feel vigilant for evidence of how they were being mistreated as a way of preparing for retaliation. Consequently, as adults, their interpersonal relationships mimic early childhood experiences of self-protective vigilance and the accumulation of caretakers' failures of empathy. Others may see them as rigid and critical of others, though this may reflect their attempt to be preemptively critical as a defense against being criticized. Hypersensitive to judgment and therefore defensive, they are quick to look for evidence of why they are not "in the wrong." They are quick to read malevolent meaning into normal situations, and adopt a defensive, "chip on the shoulder," attitude in an attempt to protect themselves from what they perceive as attacks on them. This is rarely a psychotic profile, although paranoid defenses such as projection, rationalization, and reaction formation are typical. If Scales 4 and 8 are also elevated above T -65, the probability of psychosis increases.

o Moderate to severe depression and anxiety with hypersensitivity and resentment. Both intro-punitive and extro-punitive. Depression manifested in sad mood, crying, anhedonia, depressive ideation and attitudes, impairment of concentration and reasoning, weakness and fatigue, health concerns, and disturbed sleep. Seen as moody, irritable, bitter, argumentative, resentful, and often depressed "at" others. Make others angry and resentful by their own resentfulness, in a vicious circle. May harbor fantasies of suicide to get even with others for perceived slights. Quick to take offense and feel victimized, and to interpret criticism as deliberately cruel and hostile; touchy. Projects hostility. Overreaction to imagined slights; demands for admissions of hurtful intent and reparations; these traits combined with self-defeating rigidity, hyperrationality, and a lack of impulse to forgive or reconcile often leads to hostile rejection.

Look for a history of maltreatment, chronic relationship losses, feeling trapped, current conflicts in primary relationships, escalating hostilities, and temper outbursts.

This high point pair suggests the probability of an early stage of a psychosis in a client who may be

experiencing more severe emotional difficulties than the profile ordinarily would suggest. There is a reservoir of anger and hostility present that is not entirely masked by the depressed feelings. Unlike most depressed individuals who are unable to express their anger overtly, these clients usually are openly hostile, aggressive, and resentful towards others. They adopt a chip-on-the-shoulder attitude in an attempt to reject others before they are rejected. Also, they read malevolent meaning into neutral situations and jump to conclusions based on insufficient data. Paranoid trends are rather pronounced, sometimes to the point where paranoid ideation is psychotic in nature.

Symptoms and Behaviors

The most significant feature of the 26/62 code is extreme sensitivity to real or imagined criticism. These individuals will sometimes interpret the statements of others in a way that creates rejection, yet their conclusions will be based on insufficient data. Even minor criticism is brooded over and elaborated on. Usually, they have long histories of difficulties with interpersonal relationships. Others describe them as resentful, aggressive, and hostile. To protect themselves from the impending rejection of others, they will often reject others first, which results in other people avoiding them. When they are avoided, these individuals then have evidence that they are being rejected, which gives them a justification for feeling and expressing anger. They can then blame others for their difficulties. This cycle is thus self-fulfilling and self-perpetuating, yet such people have difficulty understanding the part they play in creating the interpersonal responses directed toward them.

If Scales 7, 8, and possibly 9 are also high, a greater likelihood of a psychotic or prepsychotic condition exists, especially paranoid schizophrenia. A more controlled, well-defined paranoid system with a generally adequate level of adjustment may be suggested when Scales 2, 6, and *F* are only moderately elevated. Further possible diagnoses with the 26/62 code are a dysthymic disorder and, if Scale 4 is also elevated, a passive-aggressive personality.

Personality and Interpersonal Characteristics

Because persons with this code type are openly hostile and hypersensitive, they are likely to have poor interpersonal relationships (check the FAM/Family Problems and CYN/Cynicism scales). They are blaming, resentful, hostile, and are likely to have passive-aggressive qualities. These patterns are usually of a long-standing nature and are difficult to alter.

1. These people are touchy, take offense easily, and become tired and depressed quickly (Guthrie, 1949).
2. A great deal of other directed anger exists along with fatigue and depression (Lachar, 1974).
3. They tend to induce rejection by others.
4. This profile is of an agitated, depressed person who gets others involved in his/her problems (Caldwell, 1974).

5. Little change is likely in therapy over time and prognosis is poor (Guthrie, 1949).

6. Kelley and King (1979a) found the 2-6/6-2 profile code in a college counseling center. The clients were all women who came to counseling following a recent breakup with a boyfriend. They had numerous physical complaints and were dependent, moody, tearful, and had recently lost weight. They had suicidal thoughts and indeed had made suicide attempts in the past. They used alcohol to excess and had a high frequency of alcoholic relatives. They were diagnosed as latent schizophrenics in spite of their depressive features.

26's

Even among the medical patients studied by Guthrie, the personality problems of this group stand out more prominently than physical distress. A subgroup of his subjects with this code showed allergies or obesity, or complained of diffuse pains. More importantly, however, these patients showed strong evidence of paranoid trends; some of them were in early phases of a psychosis. In the profiles of these latter cases, there were several primed scales. Sensitivity, resentfulness, and aggressiveness were marked. These patients as a group were typically fatigued, resentful, hostile, and depressed. Their conditions were chronic and stabilized; they showed little change from one visit to another.

(Dahlstrom, Welsh, & Dahlstrom, 1979)

Description:

Mostly females, physical problems, interpersonal stress, flat affect, paranoid ideation, anger, hostility, dependent, suicidal (manipulative)

Possible Diagnoses:

Paranoid pers., Major depression, Paranoid schizophrenia, Histrionic, Borderline

Modifying Scales

- When Scale 1 is elevated, somatic symptoms such as headaches and stomach upsets reflect their tension and repressed anger.
- When Scale 3 is elevated, they will manifest more social role playing and attempts to elicit attention, flattery, and approval from others. Their depression will be masked by a veneer of social appropriateness.
- When Scale 7 or Anxiety (ANX) is elevated, the individuals will experience severe anxiety about being criticized for making a bad decision.

- When 8 is elevated—especially if Psychoticism (PSYC) or Bizarre Mentation (BIZ) is also elevated—the profile may be reflecting a thought disorder with psychotic paranoid features. The critical item endorsement will help in differential diagnosis.
- Ideas of External Influence (Pa1) elevations would suggest a recent conflict or a paranoid disturbance. Poignancy (Pa2) elevated would indicate extreme sensitivity and taking things personally. Naïveté (Pa3) elevated would predict moral rigidity, self-righteousness, and a tendency to be unforgiving and punitive toward “bad” people who need to be “taught a lesson.”

(Levak, Siegel, Nichols, & Stolberg, 2011)

Male

Nothing Low Introverted or self-conscious or socially insecure, lacks skills with the opposite sex, tense, unhappy, worries a great deal, insomnia.

Female

Low 0 Anxieties, 8+ conferences, resistant in the interview, tense on examinations, socially extroverted.

Low 1 Anxieties, 8+ conferences, lacks self-confidence, physical inferiority.

Low 3 Anxieties, 8+ conferences.

Low 4 Anxieties, 8 + conferences, shy in the interview, lacks self-confidence.

Low 5 Anxieties, depressed, nervous, 8+ conferences, wants answers, nonresponsive, lacks skills with the opposite sex, socially shy, socially insecure, indecisive, physical inferiority.

Low 7/8 Anxieties, 8+ conferences.

Low 9 Anxieties, 8+ conferences, mother conflict.

Nothing Low Anxieties, depressed, restless, 8+ conferences, lacks skills with the opposite sex.

(Drake & Oetting, 1959)

o **Check:** *ANX, DEP, DEP1, DEP2, DEP3, DEP4, RC2, RC6, HEA3, BIZ1, BIZ2, ANG1, ANG2, CYN1, CYN2, TPA1, FAM1, FAM2, WRK, PSYC, Dr1, Dr2, Dr3, Dr4, Dr5, Hy3, Pd1, Pd4, Pa1, Pf1, Pf2, Pf3, Pf4, Pa2, Pa3, Sc1, Sc2, Sc4, MDS.*

TREATMENT

This codetype is associated with childhood experiences of feeling unfairly treated by a caretaker who could be critical, judgmental, and emotionally withholding. As an adaptive response, the 26 individual may have learned to withdraw into quiet, self-protective silence as a way of manifesting hurt anger. They likely saw the demanding caretaker as impossible to deal with. Conceptually, think of the 26 individual as someone who feels wounded and in

an inescapable situation; they feel bitter and angry, and yet afraid to expose any vulnerability. They anticipate the therapist will “not understand” and will be critical. They tend to express intimate feelings in a way that others may construe as a demand or an attack that elicits from others the emotion they fear. Consequently, psychotherapy should help them learn to express underlying hurts by rehearsing expressing anger directly, without blame or judgment towards the other person. For example, they tend to express hurt in a rationalized way that comes across as blaming

the person who is frustrating them. This elicits a defensive response from the person criticized, confirming the 26 individual’s view that emotional vulnerability leads to being attacked. Cognitive behavioral techniques and educating the 26 individual on how to ask for what they want without criticizing the other person can be useful. Help them see that confrontations can be productive and not necessarily will-breaking. Assertiveness training, anger management, relaxation training, and working on the transference with the therapist can be useful. These clients feel vulnerable to the therapist and are on guard against being labeled or judged. They fear letting go of emotional control and expressing vulnerable feelings. If they cry during the therapy situation, they feel exposed and vulnerable. Exploring the transference after emotional catharsis would be important. These individuals anticipate being criticized, so they tend to make requests as a demand, which can incite the therapist’s defensiveness. These individuals are able to verbalize how disappointed they feel with someone; but, inherent in this reaction, is judgmental and subtle blame due to the inability to directly verbalize their anger.

Treatment: Rule out psychotic disorder. Lacks and resists insight into how behavior antagonizes others, and is quick to view therapist as critical, blaming, and unsympathetic. Exploratory/insight-oriented therapy is seen as threatening, intrusive, and critical in its aims. Treatment plans focused on mood disorder are generally more effective than a focus on history and relationships, at least initially. Cognitive-behavioral and skill-building approaches such as assertiveness training and anger management are helpful.

- Frequent diagnoses: dysthymic disorder; passive-aggressive personality (with elevated 4); likelihood of a psychotic or prepsychotic condition, especially paranoid schizophrenia (especially if 7, 8, and 9 are also high); well controlled, well-defined paranoid system with a generally adequate level of adjustment if 2, 6, and *F* are only moderately elevated. (Groth-Marnat, 2009)

Treatment Implications

The major challenge will be to effectively develop and maintain their rapport and trust. This will mean continually disengaging from their hostility and suspiciousness (check the ANG/Anger scale). An important area of further assessment is to determine the extent of possible underlying psychotic processes.

Therapy and Therapeutic Pitfalls

As with most depression profiles, antidepressant medications can help alleviate some of the symptoms of depression. Clients with this code dislike any medications that may inhibit their vigilance. They anticipate that questions from the therapist may be concealed as criticisms, so techniques such as motivational interviewing may increase the chance of medication compliance (Kemp, David, & Hayward, 1996). They tend to see the therapist's occasional empathic failures as a personal attack. Therapy should help them express not only their underlying hurts by rehearsing how to ask for what they want but also anger directly without blame or judgment. Because 2-6 individuals expect to be criticized and attacked, they delay expressing resentments until they feel fully justified and above possible criticism. They need to demonize people who have hurt them, perhaps as a way of rationalizing that they have "the right" to express anger. Help them to understand how their anger is a result of feeling hurt and to feel empathy for themselves. Assertiveness training, relaxation training, and education that the expressions of anger can be reasonable are helpful. Help them learn to ask for what they want before they become resentful so that they can practice negotiating their desires rather than withdrawing, feeling hurt, and then being judgmental and demanding. Insight therapy can help them to realize how they adapted to difficult childhood situations by withdrawal and self-protective, rationalized resentments and to learn how to experience a "give-and-take" relationship without blame or judgment. Suicide attempts should be taken seriously, as frequent suicidal ideation is associated with the 2-6 profile. (Levak, Siegel, Nichols, & Stolberg, 2011)

Treatment and Self-Help Suggestions

1. Learn to ask for what you want before you begin to feel resentful. Don't wait until you feel above criticism; by that time you are quite angry and bitter. When you ask for what you want, try not to tell others what they are doing wrong and how they have failed you. When you tell people how they have failed you and when you explain that what you want is reasonable and fair, others become argumentative, which only confirms your view that you are going to be criticized and judged if you ask for what you want.
2. You may have worked so hard at being above criticism that you may be out of touch with what you really want and need. Start by identifying some basic wants and physical, emotional, spiritual, intellectual, and social needs. Do

you want approval, help, more attention, and respect? Work with your therapist to choose one or two areas that would be the most comfortable for you to work on.

3. Resilience building: Learning to assertively ask for what you want will do a great deal to alleviate your depression and to give you a greater sense of self-control. Practice assertive requests with your therapist; role play situations where it is difficult for you to make requests. Assertive statements begin with “I” (e.g., I want; I feel; I think), “When you” (e.g., make jokes; don’t help with housework; have me work late hours), and “I would appreciate it if you would in the future” (e.g., not make jokes at my expense; do the dishes every other night; give me advance warning when you want me to work late).¹

4. Depression is improved by physical exercise. Avoid using chemical agents such as alcohol as a way of trying to alter your mood.

5. Explore with your therapist childhood experiences where you felt unfairly treated. As you revisit those events, rehearse how you would have liked to have expressed your anger directly but were unable to do so at the time. Role play with your therapist, expressing your hurt and anger directly without blaming or judging the other person.

6. You may believe that it is “cathartic” to express your rage. Years ago there was a popular theory that anger was a physical energy that built up inside and if unexpressed could lead to physical health problems such as cardiac disease. In truth, the expression of hostility and rage turns out to be the real culprit in heart disease.² “Venting” anger serves only to elevate blood pressure and makes us even more enraged; however, expressing anger in an assertive and direct way will lead to a reduction in anger and the corresponding physical symptoms. See item 3 for tips on assertiveness.

7. If your therapist hurts your feelings, force yourself to communicate that. Practicing expressing anger with your therapist will help you learn to express it better with others.

8. Determine what is making you feel trapped currently. You may be in a situation that reminds you of how you grew up feeling trapped and unfairly treated. It may be hard for you to see a way out of your present predicament. First determine what it is you want, and then see if you can negotiate your needs with those around you. Remind yourself that your current depression may make you quite paranoid, so that it’s hard for you to determine whether you’re seeing people’s motives clearly.

9. Forgiveness is not easy or quick, but the ability to do so leads to less anger, less stress, more optimism, and even better health.³ There are many different procedures to help you with forgiveness, but one that has had demonstrated results is to “rewrite” the offense using a more “positive” approach.⁴ Write about any benefits you may have gotten from someone’s transgression against you (e.g., a rude sales clerk saved you money because you left the store before you finished the purchase). This can be a creative way to foster a more positive outlook.

¹ There is a distinct negative correlation between assertiveness and depression; studies have found that after learning to be more assertive subjects rate themselves as less depressed (Langone, 1979; Segal, 2005). In marital discord, depression in women is associated with low assertiveness with the spouse (Christian, O'Leary, & Vivian, 1994), and in preadolescent children depression and low assertiveness were higher in girls than in boys; assertiveness is an especially important skill to teach adolescent and preadolescent girls (Suesser, 1998).

² High levels of Hostility (Ho) on the MMPI were associated with increased levels of coronary atherosclerosis. In one study, 255 medical students were assessed with the MMPI for levels of expressed hostility; 25 years later the most irritable subjects had nearly five times as much heart disease as their less angry counterparts (Barefoot, Dahlstrom, & Williams, 1983). Hostility is also associated with a lower survival rate in clients with coronary artery disease (Boyle et al., 2004).

³ In a study of 259 adults who had experienced a transgression, the subjects who completed a 6-week forgiveness program compared with a control group were significantly more likely to experience less negative thinking, less anger, and more positive health markers (Harris et al., 2006).

⁴ People who wrote about benefits they may have gotten from something negative someone did to them (as opposed to writing about their feelings or about some other topic) tended to forgive more easily (McCullough, Root, & Cohen, 2006).

(Levak, Siegel, Nichols, & Stolberg, 2011)

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you are currently feeling trapped in some situation you see as difficult, even impossible. You feel angry, hurt, and even bitter that you are in this situation, but you do not know how to get out of it. You feel this entrapping situation is due to other people who are treating you unfairly, even cruelly. You are experiencing some symptoms of depression, feeling sad, unhappy, perhaps with lowered energy and difficulties with concentration, memory, and general efficiency. You feel others may judge you as "too sensitive" because you take things personally and get your feelings hurt. There is nothing wrong with being sensitive. However, currently you may be feeling easily knocked off balance by what people say to you, how they look at you, and feel that you are being judged by others. Sometimes people with your profile grew up in environments where parents were unreasonably critical and demanding. You may have learned to withdraw, stay quiet, and protect yourself by not talking, because to defend yourself would lead to being even more criticized and judged. Now, when you are angry you may withdraw into silences that others find frustrating. You may find yourself constantly attempting to analyze whether what you've said or done is reasonable and above criticism. It may be hard for you to express anger and resentment because you do not want to be attacked or criticized for doing so. Consequently you may store

resentments and then, when you feel justified, express them in an outburst of hurt and anger. At other times you may stay silent, refusing to talk about things in case it leaves you vulnerable to being mistreated. Your therapist may want to suggest medication to help with some of the symptoms of depression, to sleep more, and to feel more efficient and energetic. Learn to ask for what you want and do not wait until you “deserve it,” by which time you feel angry and resentful. Explore with your therapist any memories of feeling hopelessly trapped in a situation that was not of your making. Role-play with your therapist standing up for yourself so that you can experience what that feels like. Learning to relax and be mindful of what you are feeling could also be useful.

Feedback Statements—Elevated Profiles (T-Score > 65)

Depression

Your profile shows that currently you are feeling quite depressed. You are likely to have difficulty sleeping—either waking up too early or having difficulty getting to sleep. You may also feel ill, may lack energy, and may feel poorly in general. You may also feel hopeless, defeated, and pessimistic about the future. When people get depressed, they often complain of tiredness, so even when you get plenty of sleep you may still lack energy and drive. You may find that your weight has changed and that eating does not provide you the reward that it used to. Also, you may find yourself having crying spells and feeling waves of sadness that overcome you and may even embarrass you.

Hypersensitive

Currently, you may be feeling so wounded that it’s hard for you to determine who you can trust. It’s as if you’re going through life vigilant to protect yourself against others’ unfairness, criticisms, or judgments. It may be hard for you to know when you are being hypersensitive and when you are seeing things accurately. Sometimes you may see people as “out to hurt you,” whereas, in fact, they were just oblivious or insensitive. In other cases, you will accurately perceive how people are mistreating you. It may be quite difficult to figure out when to trust your own judgment.

Feeling Victimized, Unfairly Treated, Trapped

Currently, you may be feeling victimized, unfairly treated, and trapped in a predicament. You may be feeling that others have treated you unfairly and that you are in a situation that offers you no way out. You may feel very hurt and wounded by what you perceive as others’ cruelty. It may be hard for you to think of any way out of this situation, so you have withdrawn to protect yourself.

Critical

Because your profile suggests that you are feeling vulnerable to criticism and judgment, it is easy for you to be critical of others, so as to protect yourself. Perhaps you're spending a lot of time thinking about how others have mistreated you, and may be you storing up evidence against them as a way to protect yourself in case they are critical of you.

Resentful

Because you are feeling so hurt, you may think a lot about how others have mistreated you. Perhaps you spend time ruminating over the specific events that hurt and disappointed you. Even when you want to think positive thoughts, it might be hard because the resentment and hurt keep invading your mind. You don't want to appear unreasonable and be criticized, so you wait until you feel completely justified in speaking up; however, this means that you store resentment, and then it becomes hard to let it go.

Irritable

When people are depressed and feel vulnerable and exposed, they are often quite irritable. The smallest setbacks or stressors make you angry. You probably don't show it directly, but others can feel your irritability as a resentment and bitterness and may feel blamed by you.

Lifestyle and Background Feedback

People with your profile often grew up in environments with critical, judgmental, and unfair parents. Perhaps you felt that no matter what you did you couldn't get the love, approval, and emotional support that you needed, and perhaps you felt criticized and judged no matter how hard you tried to do the right thing. Withdrawing from others and being mindful and sensitive to how they could potentially hurt you would make sense in such an environment. Going through life being wary of how people are mistreating you and storing evidence against them in case you need to protect yourself would also make sense given your childhood experiences. Perhaps recently you have experienced some setback or loss, which you see as the result of somebody's unfairness, criticism, or judgment toward you. Withdrawing, protecting yourself by staying quiet, not asking for what you want, and expressing anger in very careful ways would all make sense in such a situation. The current depression you are feeling has been called a trapped, hurt depression.

Normal-Range Feedback (T-score 50 to 65)

Your profile is within the normal range. People with your pattern of scores are often sensitive to criticism and work hard to avoid it. You have high standards for yourself and others. You may be going through some recent stress in which you feel unfairly treated or perhaps trapped in a current situation. You may find yourself feeling agitated and tense, with lowered energy level and sex drive, and perhaps some sleep disturbance. Your profile suggests that you have difficulty expressing anger; you tend to withdraw and become quiet instead. You may express feeling hurt more readily than you would express feeling angry. Growing up you may have felt unfairly criticized and judged, so you learned to guard against expressing any feeling that could lead to people criticizing you or controlling you. Because of this, you are more likely to analyze your feelings to make sure you are justified and above criticism before you reveal them to others. As a result, you may have difficulty forgiving people who have hurt you as you experience much stored hurt and resentment. Although you may feel justified in your anger, you may feel guilty for expressing it.

(Levak, Siegel, Nichols, & Stolberg, 2011)

267 Code

Male

Low 0 Tense, tense on examinations, indecisive, unhappy, worries a great deal, lacks knowledge or information, one interview only.

- Note: Scale coded low was infrequently associated with indecisiveness, unhappiness, worrying a great deal.

Low 1 Tense, tense on examinations, indecisive, unhappy, worries a great deal, confused, nonresponsive or nonverbal, home conflict.

Low 3/4/5/8 Tense, tense on examinations, indecisive, unhappy, worries a great deal.

Low 9 Tense, tense on examinations, indecisive, unhappy, worries a great deal, generally dependent.

Nothing Low Introverted or self-conscious or socially insecure, lacks social skills, lacks skills with the opposite sex, home conflict, mother conflict, sibling conflict, tense, tense on examinations, indecisive, unhappy, worries a great deal, insomnia, confused, nonresponsive or nonverbal.

Female

Low 0 Anxieties, depressed, 8+ conferences (26), 4 to 7 conferences (27), resistant in the interview, lacks self-confidence, distractible in study, tense on examinations, socially shy (27), socially insecure (27), socially extroverted (6-0).

- Note: Scale coded low was infrequently associated with depression, lack of self-confidence, social shyness, social insecurity.

Low 1 Anxieties, depressed, 8+ conferences (26), 4 to 7 conferences (27), lacks self-confidence, physical inferiority, distractible in study, socially shy, socially insecure.

Low 3 Anxieties, depressed, 8+ conferences (26), 4 to 7 conferences (27), cried in the interview, lacks self-confidence, distractible in study, socially shy, socially insecure.

Low 4 Anxieties, depressed, 8+ conferences (26), 4 to 7 conferences (27), lacks self-confidence, distractible in study, socially shy, socially insecure, shy in the interview.

Low 5 Anxieties, depressed, nervous, headaches, insomnia, exhaustion, 8-1conferences (26), 4 to 7 conferences (27), wants answers, nonresponsive, lacks self-confidence, indecisive, physical inferiority, distractible in study, tense on examinations, socially shy, socially insecure, lacks skills with the opposite sex.

Low 8 Anxieties, depressed, 8+ conferences (26), 4 to 7 conferences (27), lacks self-confidence, distractible in study, socially shy, socially insecure.

Low 9 Anxieties, depressed, headaches, restless, 8+ conferences (26), 4 to 7 conferences (27), lacks self-confidence, distractible in study, socially shy, socially insecure, lacks skills with the opposite sex, sibling conflict.

(Drake & Oetting, 1959)

268 Codes

o See 2-6/6-2, 2-8/8-2, and 6-8/8-6.

Male

Low 0 Introverted or self-conscious or socially insecure (28), lacks skills with the opposite sex, lacks knowledge or information, aggressive or belligerent.

- Note: Scale coded low was infrequently associated with introversion or self-consciousness or social insecurity, lack of skills with the opposite sex.

Low 1/3/4/5/7 Lacks skills with the opposite sex, introverted or self-conscious or socially insecure.

Low 9 Introverted or self-conscious or socially insecure, lacks skills with the opposite sex.

Nothing Low Introverted or self-conscious or socially insecure, lacks skills with the opposite sex, tense, indecisive, unhappy, worries a great deal, insomnia, confused.

Female

Low 0 Anxieties, depressed, 8+ conferences, verbal, resistant in the interview, distractible in study, tense on examinations, lacks skills with the opposite sex, socially extroverted.

- Note: Scale coded low was infrequently associated with depression and lack of skills with the opposite sex.

Low 1 Anxieties, depressed, 84- conferences, distractible in study, lacks skills with the opposite sex, lacks self-confidence, physical inferiority.

Low 3 Anxieties, depressed, 8+ conferences, distractible in study, lacks skills with the opposite sex.

Low 4 Anxieties, depressed, 8+ conferences, distractible in study, lacks skills with the opposite sex, shy in the interview, lacks self-confidence.

Low 5 Anxieties, depressed, nervous, 8+conferences, wants answers, nonresponsive, distractible in study, tense on examinations, lacks skills with the opposite sex, socially shy, socially insecure, physical inferiority, indecisive.

Low 7 Anxieties, depressed, 8+ conferences, distractible in study, lacks skills with the opposite sex.

Low 9 Anxieties, depressed, 8+ conferences, distractible in study, lacks skills with the opposite sex, mother conflict.

Nothing Low Anxieties, depressed, restless, 8+ conferences, distractible in study, lacks skills with the opposite sex, father conflict, mother conflict, sibling conflict.

(Drake & Oetting, 1959)

269 Code

Male

Low 0 Tense on examinations, aggressive or belligerent, rationalizes a great deal. This pattern was infrequently associated with introversion or selfconsciousness or social insecurity, shyness in the interview, being nonresponsive or nonverbal, being nonverbal or a nonrelator, indecisiveness.

Low 1/3/4/5/7/8 Tense on examinations, aggressive or belligerent, rationalizes a great deal.

Nothing Low Introverted or self-conscious or socially insecure, lacks skills with the opposite sex, tense, tense on examinations, unhappy, worries a great deal, insomnia, aggressive or belligerent, rationalizes a great deal.

- Note: Scale 9 coded high was infrequently associated with worrying a great deal and lack of skills with the opposite sex.

Female

Low 0 Anxieties, lacks self-confidence, 8+ conferences, resistant in the interview, verbal, socially insecure (29), socially extroverted (6-0, 9-0), tense on examinations, marriage oriented.

- Note: Scale 0 coded low was infrequently associated with lack of self-confidence and social insecurity.

Low 1 Anxieties, lacks self-confidence, physical inferiority, 8+ conferences, socially insecure (29), socially extroverted (9-1), vague goals.

Low 3 Anxieties, lacks self-confidence, 8+ conferences, socially insecure, vague goals.

Low 4 Anxieties, lacks self-confidence, 8+ conferences, nonresponsive, socially insecure, shy in the interview.

- Note : Scale 9 coded high was infrequently associated with shyness in the interview.

Low 5 Anxieties, depressed, nervous, exhaustion, lacks self-confidence, indecisive, physical inferiority, 8+ conferences, wants answers, verbal, nonresponsive, socially insecure, socially shy, lacks skills with the opposite sex, tense on examinations.

Low 7/8 Anxieties, lacks self-confidence, 8+ conferences, socially insecure.

Nothing Low Anxieties, restless, depressed, lacks self-confidence, 8+ conferences, socially insecure, lacks skills with the opposite sex.

(Drake & Oetting, 1959)

27/72 Codes

Code-Type 2-7/7-2

Descriptors

Complaints

Depression (slow tempo or speech, thoughts slowed down, pessimism, sadness, guilt, sleep difficulties, eating or weight problems, concentration or memory difficulties, sexual problems), anxiety, somatic concerns (weakness, fatigue, chest pain, constipation, dizziness, tingling), feeling overwhelmed, phobias

Thoughts

Hyperresponsible, prone to worry, obsessive, distracted or forgetful, painful introspection, guilt, lack of self-confidence, hopelessness, possible suicidal ideation

Emotions

Anxiety, tension, depressed, feeling on edge, quick to panic

Traits and Behaviors

Responsible, serious, meticulous, compulsive or perfectionist, inefficient, dependent, lacking in assertiveness, self-punishing, conflicted between seeking approval and fearing the limelight

(Levak, Siegel, Nichols, & Stolberg, 2011)

Therapist's Notes

When scores for the 2-7 code types are in the normal or moderately elevated range it reflects a personality pattern of organization, perfectionism, and responsibility, especially about family and financial matters. These individuals respect authority and do their best to follow the rules, even when they seem unreasonable. When elevated, the 2-7 profiles suggest an anxious, depressive state, with tension, worry, self-doubt, periods of agitation, and often multiple somatic symptoms involving appetite changes, weight gain/loss, fatigue, and insomnia. They report feeling hopeless, and unable to make even small decisions because they tend to see every side of an issue. They go through life anticipating that some unforeseen detail may precipitate a catastrophic loss that will leave them feeling disgraced and unworthy. They perceive all dangers as equally dire and can become immobilized in the face of even basic decisions. The 2-7s are highly reactive to any threats to their security. These individuals tend to catastrophize and often develop obsessive and ritualistic behaviors to reduce their anxiety. They live with a sense of guilt and dread, anticipating that, at any moment, a calamity may strike to humiliate them and leave them feeling like a failure. The 2-7 code types are often hyperresponsible, and have difficulty saying “no” to demands placed on them. Any criticism from authority figures or any perceived failure leads them into panic, self-doubt and depression. Their stream of consciousness is regularly interrupted by self-recrimination, and they never feel quite worthy of praise or acceptance. It is hard for the 2-7s to relax and they tend to feel guilty when commended for their achievements. This becomes a vicious cycle for the 2-7 because they have dependency needs for acceptance and affection, but their anxiety and low self-esteem cause them grave self-doubt so they never feel deserving of approval. Nonproductive ruminations are characteristic and are usually accompanied by feelings of inadequacy, low self-confidence and, with it, reduced work efficiency. Even though these individuals tend to be well educated and achievement-oriented, they tend to doubt themselves and feel very inadequate. A threat of failure is what usually precipitates the 2-7 disturbance. The therapist should be mindful that suicidal ideation and successful completion is a risk with this code type (Weiner & Greene, 2008; Greene, 2011).

As one would expect with someone who is highly anxious and depressed, they complain of insomnia, whether it is difficulty falling asleep or early morning awakening. They exhibit other symptoms of depression such as slowed speech and thought processes, pessimism, eating and weight problems, as well as problems with concentration and memory. Their depression is also associated with a decline in sexual interest and performance (Welling, 2003; Garvey, 1985). The 2-7 is vulnerable to guilt and self-doubt in any performance situation, so sexual difficulties are aggravated. Because of their high level of internal panic and anxiety, they will also report somatic symptoms associated with stress such as fatigue, chest pain, constipation, and dizziness. This reflects their extreme level of physical tension. Clients with a 2-7 code type have difficulty asserting themselves and feel guilty if they express anger, perhaps because of their fear of loss. Behaviorally and emotionally, the 2-7 could be seen as the polar opposite

of the 4-9 profile: the 2-7 does not act out, is self-punishing and guilt-prone, rarely feels worthy, and has fears of failure.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Lifestyle and Family Background

When 2 and 7 are elevated above a T-score of 65 and are at least 10 T-score points higher than other scales, the profile reflects a “pure” 2-7 type. The elevation of other scales would significantly alter the hypothesis about the clients’ background. The pure 2-7 profiles can be seen as hyperresponsible, guilt-prone, detail-oriented, and conflict avoidant. Look for a family history in which clients were asked to be highly responsible. In some cases, this was because of an early parental loss with clients being pressed to take on the responsibilities of an adult. In other cases, the clients’ parents were unavailable or overburdened so that they needed to take on adult responsibilities with a lack of age-appropriate feeling of being carefree. Such early expectations of a high level of performance and dependability instill a dread of failure and a feeling that mistakes could be catastrophic. It is the overcommitment to responsibilities that leads to the precipitating 2-7 disturbance.

(Levak, Siegel, Nichols, & Stolberg, 2011)

This codetype is best described as an anxious or agitated depression. It is a common codetype reflecting a hyper-responsible, prone to worry, constantly on edge, and apprehensive individual whose symptoms and complaints involve tension, depression, nervousness, anxiety, guilt, and self-devaluation. The 27 individual is painfully introspective, ruminating about his or her failings. These individuals feel inadequate, lack self-confidence, and thus are less efficient at work. They suffer from insomnia and are easily fatigued. They focus on their deficiencies, even though many are highly accomplished. As children they followed the rules and were almost never in trouble with authority. They feel obligated to take on responsibilities and then feel overwhelmed by them. Somatic complaints are common because of their high level of internal stress, even without elevations on Scale 1. They anticipate problems before they occur, but tend to panic, catastrophize, and overreact to even minor stresses. During such times they can become highly clinging and dependent, seeking reassurance at the same time as feeling guilty and unworthy of being loved. The profile reflects a defense against unpredictable loss by constantly scanning their world for danger, and rehearsing how they might deal with it. Often they develop rigid attitudes about the right and wrong way of doing things, which is heightened if Scale 4 is elevated. Internal conflicts around sexuality and fears of sexual dysfunction are common because of the person’s high level of self-monitoring and fears of failure. These individuals cannot express anger directly and feel guilt whenever they assert themselves.

Work problems are common because the 27 individual tends to see every side of an issue and has difficulty making decisions. In intimate relationships, they are dependent and lack assertiveness. They often become depressed when they have overcommitted to too many responsibilities, which they feel obligated to take on. Some have phobic symptomatology. Many are compulsive, meticulous, and perfectionistic. Quick to feel guilty and self-blaming, they are slow to celebrate their accomplishments. Paradoxically, scholastic history is often average or better, though rarely below average. A high percentage of 27/72 individuals obtain a college education, and few ever act out in aggressive ways.

Suicidal ideation, however, is common, and attempts are a real possibility. This is particularly true if Scales 8 and 9 are elevated and Scale 1 and the *K* scale are low.

o **Definition:** The specific characteristics of the 2-7/7-2 code vary considerably with the third highest scale. See especially 2-7-3, 2-7-4, 2-7-8, and combinations.

o Moderate to severe depression with tension, anxiety, worry, foreboding, obsessions and intrusive thoughts, insecurity, apprehensiveness, agitation, and introversion. Depression is manifested in dysphoria and sad affect; feelings of helplessness, hopelessness, worthlessness, pessimism, and inadequacy; suicidal ideation; self-doubt and reduced occupational performance; problems with concentration, memory, judgment, and decision making; and vegetative symptoms such as anhedonia, sleep disturbance, loss of appetite, weight loss, and loss of sexual interest. Guilt and themes of failure, uselessness, and being overwhelmed are common. Ruminates about personal shortcomings and failures, over-anticipates negative outcomes, and overreacts to minor problems and mistakes. May be over-responsible, inflexible, meticulous, and perfectionistic. Withdrawn and introverted; feels awkward, self-conscious, and easily embarrassed around others. Dependent, unassertive, and inhibited in expressing aggression, anger, and hostility. Look for conscientiousness, a history of self-denial, of achievement and taking on excessive responsibilities, and becoming overwhelmed. $2 > 7$ more common in depressive disorders; $7 > 2$ more common in anxiety disorders.

o Anxious, tense, nervous; worries excessively; vulnerable to real and imagined threat; anticipates problems before they occur; overreacts to minor stress; somatic symptoms; fatigue, exhaustion, tiredness; depressed, unhappy, sad; weight loss, slow personal tempo, slowed speech, retarded thought processes; pessimistic about overcoming problems; broods, ruminates

o Strong need for achievement and recognition for accomplishments; high expectations for self and others; guilty when goals are not met; indecisive; feels inadequate, insecure, inferior; intropunitive; rigid in thinking and problem solving; meticulous and perfectionistic; may be excessively religious and extremely moralistic

o Docile and passive---dependent in relationships; can't be even appropriately assertive; capacity for forming deep, emotional Les; elicits nurturance from others; highly motivated for psychotherapy; remains in therapy; considerable improvement likely; usually diagnosed as neurotic (depressive--- obsessive--- compulsive, anxious)

This high point pair is most common among psychiatric inpatients and suggests worry, depression, and pessimism with accompanying anxiety, tension, nervousness, and a pervading lack of self-confidence. Psychic conflicts may be represented in hypochondriachal tendencies and somatic complaints. Individuals with this high point pair are guilt ridden, intropunitive, generally fearful, and obsessively preoccupied with their personal deficiencies. The latter is in disturbing conflict with their typically perfectionistic and meticulous attitude and their strong motive for personal achievement and recognition. They have high expectations for themselves and feel rather guilty when they fail to achieve their goals. Individuals with this high point pair tend to respond to frustration with considerable self-blame and guilt. They worry excessively, are vulnerable to both real and imagined threat, and anticipate problems before they occur. Socially, they tend to be rather docile and dependent, and find it difficult to be assertive when appropriate. The prognosis in psychotherapy is excellent, as individuals with this high point pair appear motivated for help. However, if the elevation on either Scale 2 or Scale 7 is greater than a T score of 80, then the distress may be incapacitating. In such cases, psychopharmacological treatment should be considered before psychotherapy is attempted. The most likely diagnosis is some type of depressive or anxiety disorder.

Symptoms and Behaviors

The 27/72 code is extremely common in psychiatric populations and reflects persons who are depressed, agitated, restless, and nervous. Their behavior may be accompanied by slowed speech and movements, as well as by insomnia and feelings of social and sexual inadequacy. They generally spend a good deal of time anticipating problems before they actually occur and are vulnerable to actual or imagined threats. They worry excessively, often overreacting to minor events. Scales 2 and 7 reflect the relative degree of subjective turmoil the person is experiencing and they are thus often referred to as the *distress scales* (check the ANX/Anxiety, A /Anxiety, FRS/Fears, and OBS/Obsessiveness scales). Physical complaints may include weakness, fatigue, chest pain, constipation, and dizziness (check the HEA/Health Concerns scale). Moderate elevations on Scales 2 and 7 can indicate a good prognosis for therapy, because this suggests that the person is introspective and is experiencing a sufficient amount of distress to be

motivated to change. However, extreme elevations are likely to reflect a high level of disruption in his or her ability to cope. The most frequent diagnoses are affective disorders, particularly major affective disorder, although they might also have an adjustment disorder with depressed mood. Anxiety disorders are also a possibility, particularly obsessive-compulsive disorder. Possible personality disorders might be avoidant, compulsive, or passive-aggressive. However, with only moderate elevations, they may be normals who are fatigued and exhausted, with a high degree of rigidity and excessive worry. This code occurs more frequently with males 27 years or older from higher educational backgrounds. If 4 is elevated along with 2 and 7 (274/427/724), the meaning of the profile is changed. It then suggests persons who are anxious and depressed because of poor judgment related to self-indulgence, particularly related to problem alcohol or drug use (check the MAC-R, AAS/Addiction Acknowledgment, and the APS/Addiction Potential scales).

Personality Characteristics

These clients can be characterized as perfectionistic and meticulous, and as having a high need for recognition. Their thinking is often obsessive, and they experience a wide variety of phobias and fears (check the FRS/Fears scale). Interpersonally, they have difficulty asserting themselves and will be self-blaming, self-punishing, and passive-dependent (check the SOD/Social Discomfort scale). They will rarely be argumentative or provocative. Their consciences are strong and inflexible, and they will often be extremely religious in a rigidly fundamental manner. Most are married and their courtships were fairly brief, many marrying within one month of their initial dating. They are described by others as docile and dependent, and typically elicit nurturance from others. They frequently rely on their friends and family to an excessive extent. Internally, they feel inadequate, insecure, and deal with feelings of hostility in an intropunitive manner.

27/72

27/72 individuals tend to be anxious, nervous, tense, high-strung, and jumpy. They worry excessively, and they are vulnerable to real and imagined threat. They tend to anticipate problems before they occur and to overreact to minor stress. Somatic symptoms are common among 27/72 persons. They usually involve rather vague complaints of fatigue, tiredness, and exhaustion, but insomnia, anorexia, and cardiac pain may be reported. Depression also is an important feature of the 27/72 code type. Although 27/72 persons may not report feeling especially sad or unhappy, they show symptoms of clinical depression, including weight loss, slow personal tempo, and retarded thought processes. They are extremely pessimistic about the world in general and more specifically about the likelihood of overcoming their problems, and they brood and ruminate about their problems much of the time. Individuals with the 27/72 code type have a strong

need for Achievement and for recognition for their accomplishments. They have high expectations for themselves, and they feel guilty when they fall short of their goals. They tend to be indecisive, and they harbor feelings of inadequacy, Insecurity, and inferiority. They are intropunitive, blaming themselves for all the problems in their life situations. 27/72 individuals are rigid in their thinking and problem solving, and they are meticulous and perfectionistic in their daily activities. They also may be very religious and extremely moralistic.

Persons with the 27/72 code type tend to be docile and passive-dependent in their relationships with other people. In fact, they often find it difficult to be even appropriately assertive. They have the capacity for forming deep, emotional ties, and in times of stress they become overly clinging and dependent. Not aggressive or belligerent, they tend to elicit nurturance and helping behavior from other people. Because of the intense discomfort they experience, they are motivated for psychotherapy. They tend to remain in psychotherapy longer than many patients, and slow but steady progress can be expected.

Psychiatric patients with the 27/72 code type are likely to receive a diagnosis of anxiety disorder, depressive disorder, or obsessive-compulsive disorder. Diagnoses of antisocial personality disorder are very rare among persons with this code type.

Rules

2 and 7 above 70 Ts

2 greater than 7

2 minus 8 more than 15 T-scores

7 greater than 1 and 3

7 minus 4 more than 10 T-scores

7 minus 6 more than 10 T-scores

7 minus 8 more than 10 T-scores

9 below 60 Ts

L, F, and K below 70 Ts

Most Descriptive

20. Complains of difficulty in going to sleep (9.0) +

93. Exhibits depression (manifest sad mood) (9.0) + +

55. Has feelings of hopelessness (8.7) + +

- 10. Fears or phobias present (8.5) +
- 26. Reacts to frustration intropunitively (i.e., punishes self) (8.3) + +
- 1. Is vulnerable to real or fancied threat; generally fearful; is a worrier (8.0) +
- 7. Psychic conflicts are represented in somatic symptoms (8.0) +
- 21. Has multiple neurotic manifestations (8.0) +
- 56. Complains of weakness or easy fatigability (7.8) +
- 46. Is nervous; tense in manner; trembles, sweats, or shows other signs of anxiety (7.7) +
- 32. Is tense, high-strung, and jumpy (7.5) +
- 81. Is perfectionistic ; is compulsively meticulous (7.5) + +
- 60. Has inner conflicts about self-assertion (7.2) +
- 100. Obsessive thinking is present (7.2)
- 66. Is a serious person who tends to anticipate problems and difficulties (7.0) +
- 105. Manifests hypochondriacal tendencies (7.0) +

Least Descriptive

- 42. Is "normal," healthy, symptom free (1.0) —
- 39. Genotype has psychopathic features (1.5)
- 61. Tends to be flippant both in word and gesture (1.5)
- 106. Has grandiose ideas (extreme is delusions of grandeur) (1.5) —
- 64. Expresses impulses by verbal acting-out (1.7)
- 89. Is provocative (1.7) —
- 36. Has a rapid personal tempo; thinks, talks, moves at a fast rate (2.0) —
- 22. Resents authority figures and typically has impulses to resist or derogate them (2.2)
- 45. Thinks and associates in unusual ways; has unconventional thought processes (2.2) —
- 11. Is cheerful (2.3)
- 49. Appears to be poised, self-assured, socially at ease (2.3)
- 96. Genotype has paranoid features (2.3) —
- 47. Handles anxieties and conflicts by refusing to recognize their presence (2.7)-
- 72. Is demanding; tends to take the attitude "the world owes me a living" (2.7)
- 107. Would be organized and adaptive when under stress or trauma (2.7) +
- 37. Defenses are fairly adequate in relieving psychological distress (2.8) +
- 43. Undervalues and consistently derogates the opposite sex (2.8) —

80. Emphasizes oral pleasures; is self-indulgent (2.8) —

83. Is argumentative (3.0)--

98. Is egocentric; self-centered; selfish (3.0) ---

2-7 See also the 7-2 combination, p. 195.

1. These people tend to be very anxious and depressed and have feelings of worthlessness. They also tend to be agitated and obsessed about their problems (Hovey & Lewis, 1967).
2. They tend to have distress, neurasthenia (weakness), and lack of self-esteem and self-confidence (Lachar, 1974).
3. They usually anticipate problems before they occur and overreact to minor stress. Somatic problems are typically seen (Graham, 1977).
4. A person with this elevation usually has been an achiever in the past and with lower 2-7 elevations may be an achiever still. Generally, the person has been successful in his/her field. Then something goes wrong and the person reverts to child-like behavior and cannot do anything. This is especially true when scale 3 is also elevated (Caldwell, 1972).
5. This combination reflects acute distress. More severe deterioration is shown by an accompanying rise on scale 8 (Trimboli & Kilgore, 1983).
6. Suicidal preoccupation may be present with these people (check MMPI item #339). The possibility of suicide is greater when the person does not act depressed than when he/she appears deeply depressed (Good & Brantner, 1961).
7. This person is usually a good candidate for psychotherapy, because he/she is hurting so much. However, with extreme elevations, the agitation and worry may be so excessive that the person cannot sit still for therapy (Carson, 1969). Consequently, these people may need medication to quiet them so that they can participate in therapy.

8. Marks, Seeman, and Haller (1974) found the 2-7 pattern in a university hospital and outpatient clinic. These people tended to be seen as depressed and anxious. They also tended to be perfectionistic and compulsively meticulous. Because they felt they must live up to their own high expectations, they tended to be self-punishing and felt hopeless. The Marks, Seeman, and Holler book should be consulted for further information concerning this profile.
9. Gilberstadt and Duker (1965) found the 2-7-(3) pattern in a VA hospital, male population. The parentheses around the 3 are to indicate that the 3 scale elevation is above 70, but it is not necessarily the next highest scale in the profile. A man with this pattern was usually a chronically anxious, ambitious person. When he was unable to tolerate stress, he tended to become depressed, selfdeprecating, inadequate, and clinging. The Gilberstadt and Duker book should be consulted for further information concerning this profile.
10. In one study, patients with the 2-7 pattern were found to be feeling blue and depressed. They did not tend to get angry or annoyed easily, were less irritable, and socially were more competent than other patients in the study (Lewandowski & Graham, 1972).
11. Gynther, Altman, and Warbin (1973c) and Gynther, Altman, and Sletten (1973) have found psychiatric in-patients with the 2-7/7-2 pattern to have more suicidal thoughts and feelings of worthlessness than patients in general. When a patient had the 2-7 pattern, he/she had a "loss of interest" as well. They were less evasive, unrealistic, angry, hostile, deluded, and antisocial than patients in general. These researchers found this code pattern to be quite similar to the 2-7-8 pattern, and questioned the need for a separate three-point code type.
12. Adolescents in treatment with the 2-7/7-2 pattern (Marks et al., 1974) were tearful, restless, nervous, and anxious. They were also depressed, passive, and nonassertive. The Marks, Seeman, and Haller book should be consulted for further information concerning this profile.
13. Kelley and King (1980) found the 2-7/7-2 profile code in a college client population, however, too few females were found to analyze. Males had many neurotic features typical of an obsessive-compulsive individual such as perfectionism, rumination, and meticulousness.

14. These people tended to have test anxiety in college with obsessive thinking and rigidity connected with this anxiety. They were also introverted, dependent, self-conscious or insecure. They had conflicts at home usually with their mothers or siblings. They also tended to be nonverbal (Drake & Oetting, 1959).
15. More husbands from the general population have either 2-7 or 7-2 code types than do husbands in marriage counseling (Arnold, 1970; Ollendick et al., 1983).

Diagnosis

Psychoneurosis 56%+ Depressive/anxiety

Psychosis 36% Depressive

Brain syndrome 4% Chronic

Personality disorder 4%- Dependent

Personality Description

The most salient descriptive feature of persons yielding this profile is depression. The personal tempo is slowed, as is the rate of speech. Although thought processes are retarded, there is no noticeable cognitive slippage; that is, the thoughts, phrases, and ideas are "glued" together in appropriate sequence and in a grammatically and semantically sound fashion. These people are likely to express feelings of pessimism, hopelessness about the future, and even the futility of any treatment. Nevertheless, it is significant that the "projected discharge" profile for this group is within normal limits with no T-score over 70.

This constitutes a prognostically hopeful sign which contradicts the gloomy attitude so characteristic of these patients. Furthermore, the discharge MMPIs at termination of therapy conform, in large, to the "projected discharge" profile-indicating improvement. This is consistent with independent clinical ratings by therapists who judged improvement from "some" to "considerable" and reported an 85% remission rate.

The mean age of onset of disturbance was 49 years; this is significantly older than for any other profile type. In general, the disorder took somewhere from 1 month to 1 year in developing and, in 70% of the cases, there were no previous episodes. Eighty-four per cent of these patients reported having dated

frequently, 78% were married, 87% of those married reported good marital adjustment, and none were divorced. Courtship is typically short for these people and 60% married within 1 month's time.

These patients should be expected to exhibit compulsive, meticulous, and perfectionistic trends. A variety of fears and phobias are possible, as is obsessive thinking. Among multiple neurotic manifestations frequently observed are strong conflicts about self-assertion and a decided tendency toward self-blame and self-punishment. In psychoanalytic terminology, they may be said to be dominated by severe superego constraints. Indeed, they are the most rigid and the most devoutly religious of the profile types.

Tense, high-strung, nervous, anxious, and jumpy are adjectives often applied to these people. Thus, it is not surprising to observe trembling and sweating. Sleep difficulties are characteristic and should be expected. Often these patients are anorexic as well.

There are a variety of ways in which people presenting this profile express their psychological difficulties in a somatic, hypochondriacal fashion. A wide array of body symptoms may be presented; weakness and fatigue, chest pain, constipation, dizziness, and neurasthenia are some of the more common complaints.

These individuals, too, are constant worriers and are very vulnerable to threat-real or imagined. The 2-7 individual is a serious person who is given to anticipating problems and difficulties-the proverbial "crosser-of-bridges-before the-bridges-have-materialized."

The scholastic history of these patients is average or above. Twenty-eight per cent have a college education; 84% have at least a high school education. In fact,

the average IQ for this group is 114 on the Shipley and 115 on the WAIS. They place value on intellectual and cognitive activities, skills, and attitudes.

Behavioral or psychological characteristics very unlikely to be encountered in persons with this profile are flippant manner, speech, or resentment of authority figures. Adjectives used infrequently to describe them include self-centered and egocentric. Deliberately argumentative behavior or deliberately provocative behavior, verbal or nonverbal, is not likely.

This is the single most frequent high-point pair in hospitalized psychiatric groups, male and female, and is a prominent pattern among outpatient psychiatric cases and medical patients; as such, the 27 code is largely a manifestation of abnormality. Together with the similar pattern of 72, this code makes up about 15 percent of the male inpatient profiles (if scale 5 is not coded). For females, these codes make up around 11 percent of the total patterns of inpatients (again omitting 5). The prominent feature of this group in presenting complaints, according to Hathaway and Meehl (1951b), is depression, with tenseness and nervousness as frequent accompaniments. Many of these patients also suffer from anxiety, insomnia, and undue sensitiveness. For both sexes, these authors reported a modal diagnosis of reactive depression, with obsessive-compulsive neurosis a close second, but mixed psychoneuroses and conversion reactions are unlikely. However, the psychotic diagnoses were more frequent by a small margin than the neurotic diagnoses, with manic-depressive and depressed types and involuntional depressions predominating. Guthrie considered the 27 group in his sample of medical patients to be unusual in two respects: first, they were the most homogeneous group of cases among his code types and, second, they presented surprisingly few medical complaints even though they were consulting an internist. Instead, these patients complained of easy fatiguability, chronic tiredness, or exhaustion, or even more frankly of depression. The men in this group also showed rigidity and excessive worrying of the obsessive-compulsive sort. They suffered from reelings of inadequacy and from sexual conflicts. Within this group of patients, the depressed condition did not seem to be easily reversible, but remained stable over a long period. The forty items that Guthrie found to be characteristic of the cases with this code (see the Co27 scale in Appendix I in Volume II) are almost all from scales 2 and 7, particularly the items on those scales that also appear on Welsh's (1956b) A scale. The items are concerned with loss of efficiency, initiative, and self-confidence, brooding preoccupation with personal deficiencies, and discomfort in relationships with others. Drake has found that the total profile of the 27 group tends to be elevated among college counselees; these subjects frequently present various types of problems relating to home conflict. Halbower's Group II. Since Halbower found that the 27-72 combination of codes was tied for second in frequency of occurrence in his Veterans Administration mental-hygiene sample, he used this pattern as one of his criterion groups. The bases of case selection that he employed were these: the code either 27 or 72, if 7 was within 10 T-score points of 2; the third scale in the code at least 10 points lower than 2; scales 4, 6, and 8 all below 70, preferably, but he allowed 6 between 70 and 80, if Pa-subtle was higher than Pa-obvious, and 8 between 70 and 80, if 7 was at least 10 points higher than 8. As may be anticipated, Halbower's judges did not differentiate this group as clearly from the patients-in-general and from the other MM PI code groups as they did some of the other code types. From the Q-sort items chosen they identified this group as appearing intelligent, as manifesting feelings of inadequacy, inferiority, and insecurity, and as characterized by a strong motivation for personal achievement and recognition. These subjects also were described as relying heavily upon mechanisms of the internalized sort, like somatization, self-blame, withdrawal, and

obsessive-compulsive behavior. In their descriptions of these patients, the therapists used some items significantly infrequently, and in these omissions there are some interesting discrepancies with the findings of Hathaway and Meehl mentioned above for this code type. Some of these differences involved the lack of psychotic manifestations in Halbowers group, such as strange verbalizations, feelings of depersonalization, bizarre mentation, confusion, feelings of unreality, ideational poverty or inappropriate affect, or other reality distortions. The fact that these patients were selected from an outpatient treatment center may account in part for the absence of the more frankly psychotic correlates of this code type. Also, Halbower placed stringent restrictions on the range of scale 8 in forming this code group. The other omissions are consistent with the general clinical picture of these patients reported above, in that these patients do not rely upon somatic complaints to reduce anxiety, do not tend to gloss over and rationalize their problems, do not minimize their hostile feelings. These patients were also not described as either euphoric or hypomanic by the observers. Several additional subgroups within the 27 pattern have been reported in various codebooks. Marks and Seeman provide data on the 27 pattern and on 274 and 278 as well. Gilberstadt and Duker include data on these same prototype groups although the defining characteristics for their categories differ somewhat from the Marks and Seeman specifications (see Chapter 3 for the listings of these defining attributes). Forsyth and Smith (1967) included a 278 code type in their analysis of personality ratings made by group dynamics leaders on nursing school students during their group sessions. These girls were found to be readily distinguishable from other common code patterns, primarily in terms of the absence of various interpersonal styles and relationships. They were judged to be more able than other students to understand the feelings of others and having more problems with authority figures. On the other hand they were judged to be less likely to make tangential remarks or odd comments, to need to be liked, to want everyone's friendship, to be overpowering, to invite hostility, to be self-confident, stubborn, angry, busy rebelling, sarcastic, emotional, naive, anxious verbally and nonverbally, independent, outgoing, apologetic, to admire and imitate others, to be able to be indifferent to others, to be manipulative, to manage others, to ask questions continually, to monopolize group discussion, to deflate others status, to be angry or sarcastic toward the leader, to communicate with the leader, to question the leader directly, to change the topic being discussed, to be oversympathetic, to confide in the group, to allow anger to be expressed, to be uncomplicated, to be absent.

(Dahlstrom, Welsh, & Dahlstrom, 1979)

Description:

Depression, agitation, rumination, difficulties in concentration, somatic complaints, suicidal ideation, obsessive-compulsive patterns, insomnia, passivity, dependency, intrapunitive, emotionally distant, don't show anger and hostility, rigid thinking, perfectionistic, best therapy candidates

Possible Diagnoses:

Agoraphobia, Avoidant p.d., Dependent p.d., Depressions, Bipolar, Dysthymia, Alcoholism, Factitious dis., Generalized anxiety, Identity dis., Obsessive-compulsive dis., Psychogenic pain, Schizotypal p.d., Sexual masochism, Stuporous catatonic schizophrenia, Zoophilia, PTSD, Adjustment dis.

Modifying Scales

- When the Correction scale (K) is elevated, the jittery, panicky intensity of the 2-7 is muted. The therapist will have to multiply the intensity of what these clients are saying to understand the full intensity of panic and anxiety.
- When Scale 1 is coded third, the depression will be apparent in numerous physical symptoms, which create further panic and anxiety.
- When Scale 3 is coded third, expression of anger is inhibited, and the depression will be squeezed through the constraints of conformity with a desire to please and look good. They will be very suggestible to the therapist's input and to any medication side effects. The 2-7-3 will be highly conflicted about the expression of sexual and self-centered impulses and may be focused on somatic symptoms.
- Typically, the content scales Anxiety (ANX) and Depression (DEP) will be elevated, confirming the severity of the anxious depression. In the pure 2-7 code type, most content and supplementary scales will confirm the severity of anxiety and Self-Doubt (LSE1).
- Check the Critical Items for any suicide endorsements, which should be taken seriously.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Male

Low 0 One interview only, tense, tense on examinations, indecisive, unhappy, worries a great deal, lacks knowledge or information.

- Note: Scale 0 coded low was infrequently associated with indecisiveness, unhappiness, worrying a great deal.

Low 1 Tense, tense on examinations, indecisive, unhappy, worries a great deal, confused, nonresponsive or nonverbal, home conflict.

Low 3/4/5/6/8 Tense, tense on examinations, indecisive, unhappy, worries a great deal.

Low 9 Tense, tense on examinations, indecisive, unhappy, worries a great deal, generally dependent.

Nothing Low Introverted or self-conscious or socially insecure, lacks social skills, lacks skills with the opposite sex, home conflict, mother conflict, sibling conflict, nonresponsive or nonverbal, tense, tense on examinations, indecisive, unhappy, worries a great deal, insomnia, confused.

Female

Low 0 Anxieties, depressed, lacks self-confidence, distractible in study, tense on examinations, socially shy, socially insecure, 4 to 7 conferences.

- Note: Scale coded low was infrequently associated with depression, lack of self-confidence, social shyness, social insecurity.

Low 1 Anxieties, depressed, lacks self-confidence, physical inferiority, distractible in study, socially shy, socially insecure, 4 to 7 conferences.

Low 3 Anxieties, depressed, lacks self-confidence, distractible in study, socially shy, socially insecure, 4 to 7 conferences, cried in the interview.

Low 4 Anxieties, depressed, lacks self-confidence, distractible in study, socially shy, socially insecure, 4 to 7 conferences.

Low 5 Anxieties, depressed, nervous, headaches, insomnia, exhaustion, lacks self-confidence, indecisive, distractible in study, tense on examinations, socially shy, socially insecure, lacks skills with the opposite sex, 4 to 7 conferences, wants answers.

Low 6 Anxieties, depressed, lacks self-confidence, distractible in study, socially shy, socially insecure, 4 to 7 conferences, nonverbal.

Low 8 Anxieties, depressed, lacks self-confidence, distractible in study, socially shy, socially insecure, 4 to 7 conferences.

Low 9 Anxieties, depressed, lacks self-confidence, distractible in study, socially shy, socially insecure, 4 to 7 conferences, mother conflict.

Nothing Low Anxieties, depressed, headaches, lacks self-confidence, distractible in study, socially shy, socially insecure, lacks skills with the opposite sex, 4 to 7 conferences, sibling conflict.

(Drake & Oetting, 1959)

o **Check:** *ANX, FRS1, OBS, DEP, DEP1, DEP2, DEP3, DEP4, RC2, RC7, HEA3, LSE1, LSE2, WRK, AGGR* (low), *Dr1, Dr2, Dr3, Dr4, Dr5, Hy3, Pd5, Pa2, Sc2, Sc3, Sc4, A, R, Es* (relative to *K*) , *MAC-R* (low).

TREATMENT

This is one of the most prognostically favorable codetypes because these individuals are compulsive, perfectionistic, and responsible. They follow rules, feel guilty if they do not do what they are told, and are introspective. High elevations suggest a high degree of agitation, which can benefit from relaxation training and thought stopping.

However, antidepressant, anti-anxiety medications may be the most efficient way to provide the 27 individual with a sense of control. Suicidal threats should be taken seriously, especially if drug abuse is present. Early childhood histories are often associated with high levels of responsibility and a lack of age-appropriate carefreeness. A recent overload of responsibilities is often the precipitating event for a 27/72 depressive episode. Depression is also precipitated when the 27/72 individual feels that he/she have let someone down and somehow failed others.

Relaxation training, implosion therapy around fears of failure, and techniques to help them verbalize anger can be useful. Antidepressant, anti-anxiety medication, cognitive restructuring to help them turn off negative thoughts, and teaching them to switch off catastrophizing can also be useful. Help them develop a sense of empathy for themselves as highly responsible children and help them to realize how their guilt is a manifestation of their fear that they will be abandoned by loved ones unless they are perfect. Help them learn to verbalize anger towards their childhood situation, rather than at a specific parental figure, as a way of getting around their tendency to feel guilty if they express anger towards a loved one. Help them set realistic goals so that they do not overcommit. Teaching them to manage guilt through cognitive restructuring and thought stopping is important.

Treatment: Some preservation of insight, psychological mindedness, and capacity for introspection. Responds well to support, limited reassurance, structure, and graduated expectations. Cognitive and interpersonal therapies and skills training methods (e.g., assertiveness) are helpful, as are more traditional insight therapies so long as these employ measures that counteract passivity and a tendency to delay implementation of behavior change.

- Frequent diagnoses: affective disorders (particularly major affective disorder), adjustment disorder with depressed mood, anxiety disorders (particularly obsessive-compulsive disorder), personality disorders (avoidant, compulsive, passive-aggressive); may be normals who are fatigued and exhausted but who also have a high degree of rigidity and excessive worry only (with moderate elevations).
- With accompanying high 4: anxious and depressed because of poor judgment related to self-indulgence, particularly related to problem alcohol or drug use (check MAC-R, AAS/Addiction Acknowledgment, APS/Addiction Potential scales).
(Groth-Marnat, 2009)

Treatment Implications

Although 27/72 persons usually express a great deal of pessimism regarding treatment and the future in general, their psychological distress is ordinarily reactive, and in time, they can be expected to improve. For most patients having this profile, the disorder takes between one month and one year to develop, and, if they report for treatment, it will be their first need for such intervention. If these scales are extremely high, the person may be too agitated to focus and concentrate. In such cases, medication may be necessary to relax him or her sufficiently to function in a psychotherapeutic context. The presence of suicidal thoughts is a definite possibility, especially if Scales 6 and 8 are also elevated, and the suicidal potential of these patients must be carefully evaluated. They can often be extremely self-critical during therapeutic sessions and require considerable emotional support. They are prone to being perfectionistic and guilty, which frequently leads to unproductive periods of rumination. While obsessive about the possibility of change, they often have a difficult time actually attempting new behaviors. However, they generally establish new relationships relatively easily, and these relationships are frequently deep and of a long duration. When working with persons with 274/427/724 code types, their drinking patterns might be of a long-standing nature, therefore complicating any interventions. The possible presence of these difficulties should be determined early in the treatment sessions. In contrast to the pure 27/72 code type, they do not do well in individual insight-oriented therapy and are likely to terminate prematurely. There may be an initial “honeymoon” effect in which changes have apparently been made, but during times of stress, they are likely to act out and undermine any progress. They would be most likely to benefit from group interventions with a focus on clear, specific goals that would include, among other things, environmental changes.

Therapy and Therapeutic Pitfalls

Marks and Seeman (1963) found that, of all code types, individuals with a 2-7 were the most amenable to psychotherapy and the easiest to predict their adjustment at termination of therapy. Their lack of alienation—that is, the absence of elevation on Scales 4 and 8—and their neuroticism, with its associated need for approval and connection, make them amenable to psychotherapy. Insight therapy is appropriate for the 2-7s, as they tend to be intellectually oriented. These clients want approval, trust authority figures, and follow direction well. As they doubt themselves, they readily bond to a supportive, nurturing, and directive therapist. The precipitating event for therapy is usually the threat of failure or a loss of self-esteem. They crave reassurance but tend not to trust it, doubting their own ability rather than doubting the therapeutic intervention. Understanding their childhood conditioning experiences of over-responsibility and learning self-empathy can be quite useful. These clients benefit

from assertiveness training and need to learn to recognize when anger is building so they can express it directly without guilt; they are very fearful that making demands or expressing anger will lead to abandonment. They respond very well to directive and concrete therapeutic interventions. Cognitive restructuring, thought stopping, relaxation training, and meditation can all be useful (Bakker, 2009; Benson, 1983; Sanderson & McGinn, 2001; Segal, Williams, & Teasdale, 2002). They can profit from mindfulness exercises to help them to become aware of their guilt and self-recrimination. Meditation to help them experience periods of relief from anxiety can help to restore a sense of control. As with all depression and anxiety conditions, physical activity is useful as both a tension reducer and an antidepressant (Salmon, 2001). Deep breathing exercises, yoga, and other relaxation techniques are also useful to help them gain a sense of control over the power of intrusive, panicky thoughts and emotions. Insight therapy is appropriate for the 2-7 individuals as they are quite intellectual. Understanding their childhood conditioning experiences of overresponsibility and learning self-empathy can be quite useful. These clients benefit from assertiveness training and need to learn to recognize when anger is building so they can express it directly without guilt; they are very fearful that making demands on others or expressing anger will lead to abandonment. Deep-breathing exercises, yoga, and other relaxation techniques are also useful to help them gain a sense of control over the power of intrusive, panicky thoughts and emotions.

Take suicide threats seriously. Be aware that they are extremely self-critical, and be mindful that any suggestions of failure or criticism from the therapist could lead to self-destructive behavior. Careful evaluation of alcohol use and suicidality is important. Assume that the clients will take anything that is vaguely critical as a devastating judgment of them.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Treatment and Self-Help Suggestions

1. When you have stressful, anxious, or difficult times, make sure to get plenty of exercise. This will relieve some of the tension. Aerobic exercises such as fast walking, using the treadmill, swimming, or jogging are all especially effective at relieving stress and anxiety.¹

2. When you notice yourself thinking about all of the things that have gone wrong in either the past or present, realize that going over these mistakes can do you more harm than good. Reinforce a more positive and confident attitude by challenging your thinking. Work with your therapist to reword some of your self-statements that lead to anxiety. For example, instead of, "This is unbearable," try, "I can learn to cope with this." Instead of, "I feel inadequate compared with others," try, "I am learning and growing, which is a valuable experience."

3. Practicing some type of relaxation exercise on a regular basis can lead to increased energy and productivity and reduced stress and anxiety. Relaxation can lead to a decrease in heart rate, blood pressure, respiration, and muscle tension.² Yoga, meditation, biofeedback, and progressive muscle relaxation are all methods that can help you achieve a state of deep relaxation.

4. See if you can let go of some of your perfectionism—those areas where you set your standards and expectations excessively high. Instead of allowing for the unavoidable mistakes and delays that naturally come up in life, your perfectionism will keep you on the treadmill of working so hard that you ignore your own needs. Rather than dwelling on all of life's unavoidable mistakes, practice looking at the positives. Near the end of each day, list all of the positive things you have accomplished, large or small. Think of any small steps you have taken toward a goal. Try to be more generous in giving yourself credit and cultivate an appreciation for what you have achieved.³

5. Work with your therapist to identify times in your life, especially early childhood, where you had to take on too much responsibility. Develop self-empathy and compassion for an early overload of responsibility and the effects that has on you today.

6. Meditation has been shown to reduce depression, anxiety, and stress and has a great impact on repetitive negative thought patterns and worry.⁴ Through the practice of meditation it is possible to step back and observe and become free of our habitual reactions and suffering caused from automatic negative thinking. There are many forms of meditation, both structured and unstructured, and you may have to experiment to see which works best for you. You can order books or meditation tapes or CDs from the Stress Reduction Clinic at the University of Massachusetts Medical Center at www.mindfulnessstapes.com or from www.soundstrue.com.

7. Work with your therapist to identify some of the most distressing and negative “intrusive” thoughts that you have. Thought stopping is an effective technique you can practice to help you prevent these types of unwanted thoughts that can make you feel depressed or angry. Several forms of thought stopping are effective; one quick technique involves picturing or saying out loud, “Stop,” whenever you experience these types of unwanted thoughts. You then replace the thought with a pleasant image or affirmation that is more positive (e.g., “I have felt this way before, and I know I can handle this.”).

8. If you have trouble with insomnia, practice good “sleep hygiene.” Go to bed at the same time every night; make your bedroom surroundings relaxed, and keep your room dark, quiet, and at a comfortable temperature; practice relaxation techniques before bedtime; and avoid caffeine at least 6 hours before retiring.

¹ Aerobic exercise such as the treadmill or jogging is an effective coping strategy both in immediate stress reduction and also on long-term follow-up (Manger & Motta, 2005). Jogging was found to be equally effective at stress reduction as progressive relaxation (Long & Haney, 1988).

² The relaxation response describes the state of physiological response that is the direct opposite of the way the body reacts under stress and anxiety (Benson, 1983) and can be achieved through various techniques such as progressive relaxation and meditation.

³ Studies that have looked at the correlates of healthy versus dysfunctional perfectionism find that negative perfectionism involves fear of failure, avoiding negative consequences, and high parental expectations. Positive perfectionism is related to high self-esteem and positive reinforcement (Bergman, Nyland, & Burns, 2007). Working within this dual process model involves enhancing the more positive aspects of perfectionism.

⁴ Jon Kabat-Zinn (1994) did extensive research on the effectiveness of meditation in stress management; meditation has also been empirically established to help prevent the recurrence of depression (Segal et al., 2002).

(Levak, Siegel, Nichols, & Stolberg, 2011)

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests you are a dutiful, responsible, serious individual who tends to take on too many tasks and responsibilities. People with your profile often grew up in environments where they were expected to be highly responsible at a young age. No wonder you learned to worry, think ahead, and try to anticipate all possible eventualities. Now you’re going through life always analyzing almost every situation, trying to predict what can go wrong, and protect yourself against the guilt you feel when they do so. You push yourself to take on responsibilities and feel guilty if you relax or pat yourself on the back for a job most would consider well done. No wonder you wear yourself out. Your profile suggests that you may experience a constant sense of anxiety, like having butterflies in the stomach, which interferes with you relaxing and thinking clearly, and perhaps sleeping. You may have difficulties with memory and concentration, and difficulty making decisions, because you see every side of every issue. Your therapist may want to suggest medication to help you feel better, to sleep more deeply, and to be

able to think without so many internal interruptions. Medication may also help you with your anxiety. Discuss with your therapist your childhood experiences of feeling that you had to be especially responsible and dutiful. Rehearse moments of patting yourself on the back for some accomplishment. Pay attention to what that feels like and watch to see if you allow yourself to experience self-praise, or if you interrupt those thoughts with minimization or guilt. Learn cognitive behavioral techniques to switch off anxiety and guilt, imagining that they are like a faulty smoke detector that you have to sometimes ignore. Learn to be more assertive so that you can say “no” to people in order to avoid overcommitting yourself and taking on too many responsibilities, without experiencing guilt afterwards for doing so.

Feedback Statements—Elevated Profiles (T-Score > 65)

Depressed or Pessimistic

Your profile suggests that you are currently quite depressed. You may find yourself feeling slowed down and unable to be as productive as you would like. You may find that your speech is slowed down and that it’s hard to organize your thoughts and think clearly and quickly. Another symptom of depression is pessimism, feeling that life is somehow over and that the best is behind you, and you may find it hard to feel positive about the future.

Sleeping or Eating Problems

You may find that your sleep is disturbed—either it’s hard to get to sleep, or you may wake up early in the morning, with your mind racing and unable to get back to sleep. You may experience eating and weight problems. You may find your appetite severely affected so that either you eat too much or too little. Rapid weight changes would reflect the severity of your current depression.

Somatic Concerns or Memory and Concentration Problems

With your current depression, you may experience a number of physical symptoms associated with anxiety and depression. You may feel a sense of lethargy, weakness, and being easily fatigued so that it’s hard to get up, get moving, and feel very energetic. Also, you may complain of concentration difficulties and you find yourself easily distracted. It’s hard for you to focus when you’re working on things that demand concentration. You may also find that your memory is impaired so that it’s hard for you to remember even the simplest of things. All of these symptoms are the result of stress, tension, and depression. Even though they may frighten you, they are likely to be alleviated once your depression is dealt with.

Hyperresponsible or Serious

People with your profile are extremely responsible and tend to worry and fret about their responsibilities. You may find yourself thinking about all the things you should do and all the chores that you have left undone. You are a solemn, circumspect, thoughtful person; it's hard for you to be frivolous, to relax, to enjoy life, and to celebrate your accomplishments. It's hard for you to have a sense of humor because life can seem to be so serious.

Worries, Obsessions, Phobias

Much of the time, you feel a sense of worry and anxiety, as if something bad is about to happen. It's as if you go through life always on edge, waiting for some negative event to take you by surprise. You tend to obsess about a particular event or worry to such a degree that it's hard for you to let it go. People with your profile are often fearful and may even develop phobias about certain people or events. Once you've developed a particular phobia, it may be hard for you to let it go, and it may interfere with your daily functioning.

Guilt

You often feel a sense of guilt, as if you're doing something wrong now. Guilt is a regular companion, and it's hard for you to switch it off. In fact, you live with such fear of more guilt that it interferes with your ability to make new decisions.

Hopelessness or Possible Suicidal Ideation

You may feel a sense of defeat and hopelessness, as if the future is so bleak that there's no way you can succeed and get what you want. You may even find yourself fantasizing about dying. Perhaps you don't actively think about suicide, or perhaps you fantasize about possible ways of dying, but these are escape fantasies to get away from the constant sense of guilt, anxiety, and self-doubt. It is important for you to discuss these feelings with your therapist.

Dependent

Because you live with such anxiety and fear, you're likely to count on others to give you direction and even tell you what to do. You seek out others' opinion and hope they will take responsibility so that if something goes wrong you won't feel so guilty. Others may get angry with you because they feel as though you depend on them too much.

Lacking in Assertiveness

It's hard for you to get angry with anyone; you feel so guilty if you do. Because you doubt yourself and you're afraid of making mistakes or hurting and upsetting people, you may let people push you around and may avoid

taking charge of situations, fearing that you'll make a mistake. Others may get angry with you for not being more assertive and telling them how you feel and what you want. It would help you to be more forthcoming about asking for what you want and to be a little more demanding of others.

Lifestyle and Background Feedback

People with your profile often grew up in environments where they were given a great deal of responsibility at an early age. This may have been because your parents were ill or died when you were young or perhaps because they were unavailable to take on the role of the parent. You may have been the oldest child or, for some reason, were seen as the person on whom others had to depend. You likely felt quite bonded with your family so that you couldn't shrug them off or ignore their expectations. It is likely that you took on an overload of responsibility there by denying yourself many of the joys of a carefree childhood. Now you feel selfish or guilty if you take care of yourself or if you in any way take time to relax. Asking for what you want or confronting someone leads you to feel guilty. It can be hard for you to even know what you want because you're so busy trying to figure out what you "should" do. It is understandable that as a child you were so sacrificing and self-disciplined, but now you have an opportunity to take better care of yourself. If you don't, you may wear yourself out and be less available to others.

Normal-Range Feedback (T-score 50 To 65)

Your profile is in the average range. However, it does show us that you are prone to worry, especially about responsibilities and making good decisions. People with your scores tend to be on guard for unexpected problems and to overanalyze possible solutions. It is likely that that you experience mild to moderate guilt on a regular basis. Even when you finally relax, you feel like you should be doing something productive. You are very responsible, especially about family and financial matters. You respect authority, and do your best to follow the rules, even when they may seem unfair. You may be a perfectionist, wanting things to be "just right," and sometimes get stuck because you can't make the perfect decision. Periodically, as your stress builds up, you may find yourself having sleep problems, a change in appetite, and periods of anxiety and restlessness. You are quick to feel you haven't done enough, and you feel awkward accepting praise because you can always see how you could have done things better. You find it difficult to confront authority, even when you know you are correct. You may blame yourself for minor mistakes rather than see someone else as to blame. Growing up you may have had to take on more responsibilities than was reasonable for a child. Being always on guard for what can go wrong now makes sense given that you could not easily relax as a child.

(Levak, Siegel, Nichols, & Stolberg, 2011)

273/723 Codes

The addition of Scale 3 to the 27 codetype adds repression, denial, and a smiling niceness, reflecting hunger for approval and the avoidance of rejection. A 27 individual is anxious, fearful, guilty, and expresses it by being constantly over-responsible. The 273 individual is highly agreeable and self-sacrificing, smiling even through tears, eliciting positive responses from others by role-playing and fitting into others' expectations. 273 individuals are fearful of being emotionally abandoned and of having people angry and disappointed in them. Consequently their attachment style is both ingratiating and hyper-responsible, and subtly guilt-inducing. However, this constant high drive state creates physical stress, which can be manifested somatically, even if Scale 1 is not significantly elevated. They set high standards for themselves, are easily persuaded and controlled by others, and highly dependent. They can often be co-dependent because of their high needs for emotional connection and reassurance. Their niceness and, when stressed, helplessness and self-deprecating attitudes, prompt others to want to protect them and give them advice. Sexual inhibition and guilt, together with unconscious seductiveness, may lead to marital difficulties. These individuals tend to be somewhat naive and immature as well as dutiful and self-sacrificing. They go through life anticipating and preempting others' anger, and predicting possible reasons they may be rejected. As a defense, they try to placate and take care of others, inducing guilt by their self-sacrifices. They often settle with partners who are more dysfunctional than they are and become co-dependent caretakers.

See also the 2-7 pattern, points 4 and 5, p. 106.

- People with this pattern are likely to be easily led and dependent. They usually encourage others to come to their aid, particularly therapists (Carson, 1969).

TREATMENT

The addition of Scale 3 predicts repression, denial, need for reassurance, and lack of insight as well as the anxiety and depressive symptoms associated with 27 elevations. The recounting of painful events can create such anxiety that the individual may experience episodes of panic, fainting, or other somatic manifestations of emotional overload that interrupts the clinical interview. At the same time, "flights into health" are common after brief psychotherapy once a particular issue has been temporarily resolved. They return to therapy when anxiety reoccurs. These individuals lack emotional self-awareness, especially around anger and sadness. They respond well to a nurturing, non-aggressive, non-pushy therapist who takes the role of a supportive parent, viewing them as agreeable children traumatized by unpredictable catastrophic events. Help them engage self-empathy and catharsis, by exploring how repressing emotions and being "brave" was an adaptive response to overloads of emotional pain. Their transference tends to

involve fearing the therapist is impatient or angry over their lack of progress. Cognitive therapy to help them recognize “reasonable” anger and rehearsing expressing it in therapy are useful. Assertiveness training and teaching self-soothing when flooded with anxiety is also helpful. Once trust and some emotional control have developed, implosion therapy can teach them anxiety control. Thought stopping, cognitive behavioral techniques, and relaxation training are all useful.

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you are a dutiful, responsible, and agreeable person who avoids conflict. You’ll go the extra mile to understand somebody else’s perspective and meet their needs. People with your profile often experienced unpredictable anger or some other kind of unpredictable, painful losses growing up. From an early age you had to be brave, to be “a good soldier,” and not let yourself feel in order to avoid more unbearable emotional pain and not upset those around you. Smiling through your difficulties and constantly rehearsing how you “should be” in order to please others have now become a pattern of behavior for you. You might find yourself taking care of others and nurturing people around you, even when they take advantage of you or try to control you. Sometimes people with your profile literally smile through their tears as they try to be nice to others, to be hyper-responsible, and in the process, not take enough care of themselves. Your therapist may suggest medication to help with some of the symptoms of depression such as sleeplessness, fatigue, physical symptoms, and anxiety. At the same time it might be useful to explore childhood moments when you felt overwhelmed by emotional pain and you had to numb yourself and smile through things. Learn to assert yourself and recognize when being angry can be reasonable so that you are able to set boundaries with people and not let them take advantage of you. Learn to stop some of your guilty thoughts and not take on too many responsibilities. Whenever your physical symptoms increase, examine whether you are experiencing stress or whether you need to express some resentment or anger toward others that you feel guilty expressing.

2731 Code

- These people may be socially dependent, but they are not typically a member of any group (Caldwell, 1972).
- They tend to have much self-pity and self-blame (Caldwell, 1972).

274/724 Codes

This codetype reflects the impulsive (high Scale 4) and, at times, self-defeating reduction of tension associated with elevations on Scales 2 and 7. These individuals act out when they are anxious, needy, bored, or emotionally unsettled. The codetype reflects a learned pattern of immediate tension reduction because childhood experiences of being soothed by caretakers were based on the caretaker's needs, not the child's needs. Anxious and needy of reassurance, insecure and anticipating emotional abandonment, they experience approach-avoidance conflicts in their primary relationships. This reflects their experience with a caretaker who would be unpredictably available and unpredictably abandoning. They do not trust that others will be emotionally available and, because of anxiety and immaturity, they make poor attachment decisions. They become tense and quickly overwhelmed; they self-soothe by acting out impulsively and, consequently, self-defeatingly—if not self-destructively. After acting out, they may feel profound guilt and invite others to rescue and reassure them. Anxiety, worry, and depression are characteristic, and are typically combined with feelings of inadequacy, low self-confidence, and of being a failure. They show exaggerated self-criticism whenever things go wrong, which undermines others' anger, but also elicits reassurance. The 24 codetype predicts self-defeating, impulsive depression, whereas the 27 codetype predicts hyper-responsible, goal-directed proneness to worry, and feelings of inadequacy. This combination of elevations portrays an individual who compulsively worries and seeks reassurance, but is unable to trust it when it is given; they then act out, feel guilty, and seek further reassurance.

Fears and phobias may be present, and the 274 individual tends to overreact to minor issues. They complain of depression, with sad moods and difficulties with sleep and general efficiency. They are high-strung, jumpy, and easily fatigued. They want to be taken care of, but distrust it when given, and easily feel trapped by the dependencies they create. They have strong needs for attention and many exhibit somatic symptoms.

Men with this profile often have histories of being emotionally rescued by their mothers and tend to replicate this pattern in adult relationships. Though seeking such dependent relationships, at the same time they resent the control that comes with them. Often they seek older, motherly partners.

Women with this profile have often had close relations with their fathers, who tended to indulge them, but also unpredictably withdraw from them. These women often seek older, nurturing males and, reflecting their needs for closeness and yet fears of being controlled, many have affairs with married men. Substance abuse is common with this codetype, as one would expect with their needs for impulsive tension reduction.

Rules

2, 7, and 4 above 70 Ts
2 minus 4 less than 15 T-scores
2 minus 7 less than 10 T-scores
7 greater than 1 and 3
7 minus 4 less than 10 T-scores
7 minus 8 more than 5 T-scores
8 greater than 9
9 above 40 Ts
L and K below 70 Ts, F below 80 Ts

Most Descriptive

- 1. Is vulnerable to real or fancied threat; generally fearful; is a worrier (8.2) +
- 10. Fears or phobias present (8.2) +
- 46. Is nervous; tense in manner; trembles, sweats, or shows other signs of anxiety (8.2) +
- 57. Seems unable to express own emotions in any modulated adaptive way (8.2) +
- 16. Is overanxious about minor matters and reacts to them as if they were emergencies (8.0) + +
- 93. Exhibits depression (manifest sad mood) (8.0) +
- 20. Complains of difficulty in going to sleep (7.8)
- 58. Tends to be ruminative and overideational (7.8) +
- 82. Gets appreciable "secondary gain" from symptoms (7.8) +
- 32. Is tense, high-strung, and jumpy (7.6) +
- 34. Undercontrols own impulses; acts with insufficient thinking and deliberation (7.6) +
- 47. Handles anxieties and conflicts by refusing to recognize their presence (7.6) + +
- 56. Complains of weakness or easy fatigability (7.6)
- 75. Has inner conflict about emotional dependency (7.6) +
- 77. Is tearful and/or cries openly (7.6) +
- 5. Possesses a basic insecurity and need for attention (7.4) +
- 7. Psychic conflicts are represented in somatic symptoms (7.4)
- 100. Obsessive thinking is present (7.4) +
- 83. Is argumentative (7.2) +
- 14. Utilizes acting-out as a defense mechanism (7.0)
- 65. Has an exaggerated need for affection (7.0)

- 73. Is excitable (7.0) +
- 78. Is irritable (7.0)
- 85. Has inner conflicts about sexuality (7.0)

Least Descriptive

- 11. Is cheerful (1.6)
- 42. Is "normal," healthy, symptom free (1.6)
- 37. Defenses are fairly adequate in relieving psychological distress (1.8)
- 49. Appears to be poised, self-assured, socially at ease (1.8) —
- 51. Exhibits good heterosexual adjustment (2.0) —
- 63. Has a resilient ego-defense system; has a safe margin of integration (2.0)
- 107. Would be organized and adaptive when under stress or trauma (2.0)
- 24. Spends a good deal of time in personal fantasy and daydreams (2.2)-
- 31. Has a high aspiration level for self; is ambitious; wants to get ahead (2.2)
- 53. Is open and frank in discussing problems (2.2)
- 104. Delusional thinking is present (2.2) —
- 41. Has good verbal-cognitive insight into own personality structure and dynamics (2.4)
- 103. Reports difficulty in thinking; can't concentrate (2.4)— —
- 106. Has grandiose ideas (extreme is delusions of grandeur) (2.4)
- 30. Has "diagnostic" insight; awareness of the descriptive features of own behavior (2.6)
- 59. Is socially extroverted (outgoing) (2.8)
- 6. Places value on intellectual and cognitive activities, skills, and attitudes (3.0)
- 27. Has shown ability to talk about conflicts in most areas (3.0) —
- 36. Has a rapid personal tempo; thinks, talks, moves at a fast rate (3.0)
- 38. Is suggestable; overly responsive to other people's evaluations rather than own (3.0) —
- 43. Undervalues and consistently derogates the opposite sex (3.0) —
- 67. Is able to sense other person's feelings; is an intuitive, empathic person (3.0)
- 86. Is shy, anxious, and inhibited (3.0)
- 88. Is readily dominated by others; is submissive (3.0) —
- 90. Is apathetic (3.0)
- 101. Utilizes intellectualization as a defense mechanism (3.0)

2-7-4 See also the 2-7-4-Ipattern, p. 109.

- This pattern tends to indicate a situational depression (Caldwell, 1972). However, Lachar (1974) has found the chronic and expressed as feelings of inadequacy and lack of self-confidence. A person with this combination may be passive-aggressive and response to treatment may be quite poor.
- Gilberstadt and Duker (1965) found the 2-7443) pattern in a VA hospital male population. The parentheses around the 3 are to indicate that the 3 scale is elevated above 70, but it is not necessarily the next highest scale after the 4 scale. A patient with this profile tended to be a hostile, passive-aggressive, anxious, immature person who also had feelings of inferiority. Chronic alcoholism also was Found with this pattern. The alcoholism tended to be associated with the anxiety and tension. The Gilberstadt and Duker book should be consulted for further information concerning this profile.
- Marks, Seeman, and Haller (1974) found this 2-7-4/2-4-7/4-7-2 pattern in a university hospital and outpatient clinic. People with this pattern tended to be depressed and have many worries. They were usually described as passive aggressive, generally tearful, full of fear, nervous, and irritable. The Marks, Seeman, and Haller book should be imnsulted for further details concerning this profile.
- If a person with this combination is an alcoholic and stops drinking and then his/her life situation gets better, the person may become depressed and revert back to alcohol (Caldwell, 1972).
- 5. A man with this profile may have been a mama's boy, and his mother always came to his rescue. He often marries a woman similar to his mother, and if the wife also tries to rescue her husband and is unsuccessful, she may become sick (Caldwell, 1972).
- 6. Women with this profile tend to be daddy's girls. They may have long affairs with married men. They may have problems because of poor relationships with others and want to be rescued (Caldwell, 1972).
- Females with this combination and a low 5 scale tend to show the same behavior as men with the 2-7-544) pattern.

Diagnosis

Psychoneurosis 43%+

Depressive

Personality disorder 33%+	Passive-aggressive
Psychosis 19%-	Mixed
Brain syndrome 0%	

Personality Description

Patients who present this profile are, like patients with the 2-7 profile, fearful and worrisome. Because their threshold for threat is exceedingly low, they are vulnerable to it—both real and imagined; what to others might appear as trivial or minor irritants become "federal cases" for them. They tend to overreact and almost everything seems to be an emergency. Depression (manifest sad mood) is a predominant feature of the symptom picture—hence morale is impaired. Many of these patients are tearful and cry openly.

Complaints of

weakness and easy fatigability are reported with high frequency. Adjectives used by their therapists to describe them are excitable, tense, nervous, sweating, and high-strung—all indicators of anxiety-proneness. Strong emotional reactivity is noted, such that these patients seem unable to control, to adapt, to modulate, or to "tone down" their behavior. With scale 7 part of the defining code, it is hardly surprising that therapists note the presence of phobic reactions and find ruminative, obsessional ideation characteristically present. Therapists also judge them to derive appreciable secondary gain from their symptoms, which represent essentially the somatic expression of psychological conflicts.

These patients are perceived by clinicians as suffering from basic insecurity, unfulfilled needs for attention, and exaggerated needs for affection. Conflict is generated when these magnified needs collide with fears of emotional dependency. Seventy-one per cent of these patients express feelings of inferiority. In addition, clinicians are impressed with the presence and role of internal conflicts about sexuality. The reader who is interested in the theory underlying MMPI variables might find it instructive to study the differences in traits and dispositions of persons yielding this code and those yielding the Adult 2-3-1 and 2-7 profiles. (See Meehl, 1972, on a "theory-sketch of the basic temperamental parameters" underlying the scale 4 construct.) Scale 4 is a construct related to (1) undercontrol of impulses, (2) poor socialization, and (3) irritable rebelliousness. Its influence can be noted when patients generating the 2-7-4 profile

are compared with those of other code types. The Q statement "Is argumentative" appears at the low end of the 1 to 9 Q-sort scale (mean placement 2.8) for patients with the 2-7 profile; this is to say that this statement is "least characteristic" for this type. The same statement appears at the high end of the scale (mean placement 7.2) for patients with the 2-7-4 configuration; this is to say that this statement is "most characteristic" for this type. For the 2-7-4 type, "Is irritable" has a mean placement of 7.4, while for the 2-7, the placement drops to 5.8 and for the 2-3-1, to 5.4. The statement "Undercontrols own impulses, acts with insufficient thinking and deliberation" has a mean rating of 7.6 for the 2-7-4 type and yet drops to 3.3 for the 2-7 type, although these two groups share two scales in common. Consider further, "primary narcissism" as part of the theory-sketch for the scale 4 construct; for the 2-7 patient, the item "Is egocentric, selfish" is sorted low (mean placement 3.0), while for the 2-7-4 patient, the rating given is 6.8. While 78% of the 2-7 type are married, none are divorced; 80% of the 2-7-4 type are married, yet 15% are divorced. While 84% of the 2-7 patients report having dated frequently, 63% of the 2-7-4 patients never dated or did so only on rare occasions.

TREATMENT

Usually, the precipitating event is the perceived loss of a nurturing, supportive parental figure. These individuals need a great deal of reassurance, but as expected with Scale 4 elevations, they tend not to trust it when given. Insight therapy could be useful in helping them understand how early childhood experiences of unpredictable parental withdrawal could have led them to develop the adaptive defense of constantly anticipating rejection and therefore regularly seeking reassurance. As children, few had severe behavioral problems. Many of them are the youngest siblings. Therapy should focus on helping them to identify when stress is accumulating and then rehearsing tension-reducing behaviors rather than impulsive self-defeating ones. Help them to see how they tend to panic over minor stresses and act out. Rehearse new coping strategies for stressful situations. Relaxation training, thought stopping, mindfulness therapy, and exercise can all be useful in giving them a sense of control as well as reducing anxiety. In therapy, revisit childhood experiences of unpredictable emotional abandonment and moments when they experienced high levels of anxiety with no one to turn to. Helping them to learn self-soothing techniques in the face of panic and anxieties would be important.

THERAPEUTIC FEEDBACK LANGUAGE

Your profile shows that you are currently suffering from a high level of anxiety and worry. It is as if you're going through life constantly on edge, examining every possible situation for how it could go wrong and lead to unpredictable abandonment by the people you love. People with your profile grew up in environments where a parent was both highly protective and very involved in taking care of you, but at the same time unpredictable and occasionally abandoning you emotionally. From an early age you were never quite sure whether you could trust that your needs would be taken care of. Consequently you were always a little anxious, always feeling as if something bad was about to happen, and never quite feeling comfortable that you could relax and switch off your anticipatory worry. Now you're going through life often on edge, analyzing every situation and worrying that something bad is about to happen. As tension accumulates, you likely do something impulsive to feel better, which ends up backfiring and making you feel guilty. You want to feel close and connected to others, but at the same time you're afraid that if you trust and let down your guard, others will abandon you or attempt to control you in ways that do not help you feel safe. Consequently you find ways to be close to others, but at the same time you push them away, perhaps in your mind, because you're afraid that you're going to be controlled. If someone cares for you, it makes you wonder if you're good enough, like the famous quip about not wanting to be in a club that accepts you.

You might find yourself manipulating others subtly in order to take care of you, but then pushing them away when they get close. You probably suffer from a constant sense of anxiety, as if you do not feel safe in the world. Your therapist may suggest medication to help you feel better. Sleep, concentration, memory, sex drive, and appetite may all be affected by your high level of anxiety and resulting feelings of exhaustion. Work at controlling your guilty feelings and switching them off when they are inappropriate. Rehearse with your therapist ways you can deal with anxiety and panic attacks so you do not act impulsively and later regret it. Work with your therapist on identifying times in your childhood when you felt alone and overwhelmed by anxiety, with no one to turn to. Develop some empathy for yourself as a child so that you can learn ways to soothe yourself rather than relying on being manipulative or impulsive.

274(5)

(5 Scale T = 45 or Below)

In this pattern, the 4 scale is elevated above 70, but it is not necessarily the -text highest scale after 7. Females with this pattern tend to show the same behavior as men with the 2-7-54) pattern.

275/725

(for Men) and 27, Low 5 (for Women) Codes

The addition of an elevation on Scale 5 for men, or a low Scale 5 for women, suggests increased difficulties with assertiveness and exaggerates the passivity evidenced by the 27/72 codetype. The sensitivity, fussiness, and awareness of interpersonal relationships associated with Scale 5 elevations aggravate the introspective, depressive qualities of the 27 codetype. These individuals feel they are a failure, are quick to describe themselves as inferior, and they feel guilty and inadequate. They extol others' virtues at their own expense, their submissiveness perhaps serving as a defense against others' aggression. If Scale 4 is low, they are even less assertive, and exhibit low sex drive and an even greater adherence to rules and regulations than is typical with the 27/72 codetype. It is as if these individuals are continually maintaining control over the onset of unpredictable criticism by creating relationships in which they are belittled. Sexual difficulties because of performance anxiety are common.

TREATMENT

(SEE TREATMENT SECTION UNDER THE 27/72 CODETYPES)

The addition of Scale 5 for men suggests an even greater need for assertiveness training and self-esteem building. Cognitive therapy could focus on their tendency to overanalyze their interpersonal relations to the point of being immobilized by their negative introspections. Sex therapy can be an avenue to help them learn the pleasure others can experience when they are absorbed in their own sexuality.

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you are a very dutiful, responsible, and prone to worry individual who dislikes conflict and tries to solve interpersonal problems by being analytical and understanding of others. However, you may hang back and not assert yourself because of not wanting others to feel in any way pushed or bullied. You are a perceptive, artistically inclined person who tends to be philosophical, thoughtful, and creative. Your deep sense of empathy may hinder you in enjoying occasional moments of self-indulgence even though others would find it rewarding to please you. (See 27/72 codetype for further feedback.)

2754

- In this pattern the 4 scale is elevated above 70, but it is not necessarily the next highest scale after 5. Males with this combination usually try to look weak and submissive (Carson, 1969).
 - a. They are self-effacing and try not to show any strength.

b. They seem to ask others to act superior to them and are usually most comfortable when others act this way toward them.

- Males with this combination tend to be ambivalent and have a sense of failure (Caldwell, 1972).

Code-Type 2-7-8

Descriptors

Complaints

Anxiety, fearfulness, sometimes specific fears and phobias, anhedonia, depression, dysphoria, rumination, worry, self-doubt, difficulties in concentration and memory, poor sleep and tiredness, general inefficiency, somatic preoccupations and complaints, weight disturbance, psychotic thought process in rare cases

Thoughts

Suicidal ideation, self-doubt, guilt, fear of failure and rejection, self-critical, over-analytical, hyper-vigilant, preoccupied with esoteric philosophies and religious beliefs, magical ideation, self-critical and perfectionist, ideas of reference, preoccupations with being damaged and defective

Emotions

Fearful and apprehensive; highly reactive to minor upsets; depressed; dysphoric, anhedonic; feeling inferior, defective, and damaged; resentful; feeling unlovable; feeling doomed, hopeless, and helpless; feeling guilty, unsuccessful, undeserving

Traits and Behaviors

Self-defeating, self-destructive, sometimes suicidal, apprehensive, fearful that an unpredictable event will lead to catastrophe, fear of rejection by others, passive, socially withdrawn, masochistically dependent, compulsive, meticulous and perfectionistic but also procrastinating

(Levak, Siegel, Nichols, & Stolberg, 2011)

Therapist's Notes

In the normal or moderately elevated range, people with this profile are described as meticulous, perfectionistic, and self-critical, with a tendency for the observing ego to be controlling their lives. When elevated, the 2-7-8 individuals are depressed, anxious, ruminative, and insecure. They are often confusing to therapists because some are able to play a jovial and hypomanic role. Woody Allen portrays one manifestation of the 2-7-8 code type as self-deprecating, self-critical, and self-effacing, perhaps as a way of preempting criticism or judgment. In most cases, however, 2-7-8 individuals are withdrawn and highly inhibited. Most also score highly on Social Introversion (Si), which aggravates social difficulties stemming from their insecurities. They often have a dominant observing ego so that they stand back and monitor themselves, which hampers their ability to be spontaneous. Extreme self-consciousness reflects their fear that spontaneity will lead to humiliation. This self-consciousness is sometimes palpable in the interview, wherein they can come across as stilted and flat. They live in fear of being criticized, humiliated, or rejected. Sometimes they are not aware of these feelings, which have become egosyntonic. They are, however, aware of a pervasive feeling of dread and guilt without any particular content. In their interactions with others, they focus on how they could be humiliated and rejected. They live as if at any moment some disaster will strike for which they will be blamed, criticized, or judged. Due to heightened tension and anxiety, some, but not all, 2-7-8 profiles report somatic symptoms of stress. In some cases, depression is the result of their anxiety and low self-esteem. In other cases, depression is primary and the anxiety and self-doubt are secondary. It is important to parse the relative contributions of depression and anxiety in this code type to tailor their treatment. Because they are perfectionists, they can also be highly inefficient, delaying making decisions and putting off engaging in purposeful activity out of a fear of failure. In the absence of medical evidence, when they complain of odd or bizarre somatic preoccupations these beliefs can be a manifestation of profoundly negative self-esteem, and the somatic complaints can be an unconscious symbol of feeling like “damaged goods.” Most are not overtly psychotic, though some 2-7-8 individuals exhibit severe depression with psychotic symptoms. They report feelings of de-realization and depersonalization, reflecting their tension and fears of letting go of emotional control. Classic vegetative symptoms of depression such as sleep and weight disturbance, fatigue, pessimism, and, in some cases, suicidal ideation are typical. Concentration and memory are often adversely affected. They have difficulties asserting themselves, tending to be passive; anger is often expressed in self-defeating ways followed by guilt and rumination about having expressed it. They give others power to control them and then ruminate about feeling controlled. Sometimes their anxiety is manifested as specific fears and phobias, though they experience a generalized anxiety state. Some will attempt to control their anxiety through specific compulsions and superstitions. Stress tends to become a critical and potentially panicking event. This response makes sense given their preoccupation with unpredictable, humiliating loss. Some find meaning in life through esoteric religious and philosophical ideas, which serve to justify their suffering, to rationalize their eccentricities, and to provide meaning in their lives. People with

this profile are apt to have difficulties in interpersonal relationships because they assume they are somehow defective and unlovable. When involved in a relationship, they tend to be critical and doubting of their partner's value. In other cases, they focus their anxiety on preventing or minimizing real or imagined rejection. (Levak, Siegel, Nichols, & Stolberg, 2011)

Lifestyle and Family Background

Clients with this profile experienced childhoods where they lacked basic emotional security. Some clients may have experienced a death in the immediate family, some had parents who were hovering and robbed them of feelings of personal efficacy, and others had parents who overprotected them in a way that was humiliating and robbed them of self-esteem. The common ingredient is that they never learned self-confidence. From an early age, they felt insecure, fearful, inadequate, and unlovable. Look for childhood histories that conditioned in them a feeling of dread and a sense that they could not trust themselves to manage the vicissitudes of life. They often were highly sensitive children, perhaps experiencing separation anxiety and homesickness when separated from their parents.

We hypothesize that the 2-7-8 response of alertness to possible loss, humiliation, and rejection is an understandable adaptive response to having experienced there in the past. Analyzing one's internal and external environment, having the observing ego in constant control, and feeling low self-worth serves to heighten vigilance, self-protection, and the avoidance of experiencing the shock of unpredictable humiliating loss.

(Levak, Siegel, Nichols, & Stolberg, 2011)

The addition of Scale 8 to the 27/72 codetype predicts an individual who has experienced damage to their self-esteem. 278 individuals are anxious, worried, tense, and insecure, with ruminations that tend to be morbid, reflecting a basic fear that they are damaged and unlovable. They report feeling tense, anxious, depressed, and filled with self-doubt. They are constant worriers who chronically feel "a day late and a dollar short," a sense of urgency and impending doom. Many exhibit fears or phobias. They feel nervous and exhibit signs of anxiety. Sleep, concentration and memory difficulties, decreased sex drive, weight problems, and general inefficiency are typical. They feel hopeless and report difficulty in thinking, concentration, and memory. They tend to ruminate constantly, analyzing their own and others' behaviors, anticipating humiliating rejection. Suicidal thoughts, suicidal attempts, and a history of previous psychiatric hospitalizations are common. Insomnia, obsessive thinking, somatic preoccupation, fears, and phobias are also common. These individuals constantly analyze their weaknesses and vulnerabilities.

Inelegantly, but descriptively, they can be described as psychological "scab pickers." Some exhibit meticulous and perfectionistic traits, and set unreasonably high standards for themselves. They feel intense guilt when they fail to

meet their standards. Under the stress of anticipated failure, the 278 individual can become so cognitively disorganized by their “internal noise” that they are unable to function efficiently. Others may erroneously judge them as lazy because they are so inefficient, but their inertia reflects their psychological overload. Using a computer analogy, it is as if “all their windows” are simultaneously open so that they are overloaded with fragments of thoughts, but without any coherent cognitive stream. Excessive punitive introspection and self-criticism contribute to their difficulties with concentration and performance, which in turn aggravates their anxiety and depression. Histories of personal isolation and withdrawal are typical. They have difficulty making emotional commitments, and tend to focus on the negative details of their relationships, analyzing what’s wrong with their mate and oscillating between profound fear of rejection and fears that they are trapped with someone who must be defective if they feel love towards the 278 individual.

Suicide is a possibility as this codetype is most commonly associated with successful suicide. This is especially true if Scale 4 is coded fourth. If Scale 0 is elevated, the depression, social withdrawal, and insecurity are exacerbated by shyness and feelings of physical inferiority. If Scale 4 is below 60, passivity and submissiveness are also exaggerated, with an accompanying reduction of sexual interests.

Women with 278/728 codetypes with low *T*-scores on Scale 5 will exhibit passivity to the point that they allow others to abuse them. They may complain of headaches, backaches, and sexual and intimacy problems.

o **Definition:** With 2-8-7 and 8-2-7 codes, consider interpretation under the 2-8/8-2 code.

o Moderate to severe depression with suicidal ideation, anxiety, fearfulness and phobias, anhedonia, obsessional worry and rumination, compulsions, self-depreciation, psychomotor retardation, pessimism, tension, agitation, and negative self-concept. Feelings of worthlessness, hopelessness, helplessness, inadequacy, and inferiority. Severe impairment in concentration and decision making, but memory, judgment, reasoning, and problem solving are better preserved than in 2-8/8-2. May be periodically disoriented. Tends to ruminate and obsess about own faults, guilts, and failures, and about potential future catastrophes. Markedly intro-punitive; may be compulsively self-critical and self-accusatory. May gravitate toward esoteric ideas, philosophies, and religions; magical ideation. May be seen as deliberately self-defeating by setting unrealistically high standards for his or her performance, but fearful about his or her ability to meet challenges and responsibilities. Compulsive, meticulous, and perfectionistic. Apprehensive and overreactive to minor upsets or mishaps. Vegetative signs of depression, including sleep disturbance, weakness, tiredness, and fatigue; somatic complaints such as GI problems are common. Catastrophic concerns about physical illness. Schizotypal features are common in the absence of manifest psychosis. Derealization

and ideas of reference are usually tied to the patient's sense of personal sinfulness, evil, or inferiority. Introverted, socially self-conscious, and avoidant, but may seek support. Sensitive. Ambivalence in close relationships with fear of emotional involvement. Conflicted about dependency, fearful of domination, but tends to be trusting of authority. Look for manifest psychotic ideation, thought disorder, hallucinations, and delusional ideation; a history of social isolation; and identity and sexual concerns. May be severe suicide risk.

o Has features of both psychosis and neurosis; often diagnosed as pseudoneurotic or latent schizophrenic; brief acute psychotic episodes; tense, nervous, fearful; feels depressed, despondent, hopeless; suicidal ruminations; blunted or inappropriate affect; problems in concentrating and attending; schizoid life---style; isolated, shy, withdrawn, introverted; lacks basic social skills; feels inadequate and inferior; sets high standards for self and feels guilty when they aren't met; somatic symptoms; interested in obscure subjects

278/728

Persons with this code often present a mixed picture diagnostically. They are experiencing a great deal of emotional turmoil, and they tend to have a rather schizoid life-style. Brief, acute psychotic episodes may occur. They tend to feel tense, nervous, and fearful, and they have problems in concentrating and attending. They feel depressed, despondent, and hopeless, and they often ruminate about suicide. Affect appears to be blunted or otherwise inappropriate. These persons lack basic social skills and are shy, withdrawn, introverted, and socially isolated, they feel inadequate and inferior. They tend to set high standards for themselves and to feel guilt) when the standards are not met. They tend to show interest in obscure, esoteric subjects.

Rules

2, 7, and 8 above 70 Ts

2 minus 1 more than 15 T-scores

2 minus 8 less than 15 T-scores

7 minus 4 more than 10 T-scores

7 minus 6 more than 10 T-scores

7 greater than 8 (or 8 minus 7 less than 5 T-scores)

7 and 8 greater than 1 and 3

9 below 70 Ts

0 above 70 Ts

L and K below 70 Ts, F below 80 Ts

Most Descriptive

- 1. Is vulnerable to real or fancied threat; generally fearful; is a worrier (8.8) +
- 21. Has multiple neurotic manifestations (8.6) + +
- 10. Fears or phobias present (8.4) +
- 46. Is nervous; tense in manner; trembles, sweats, or shows other signs of anxiety (8.4) +
- 20. Complains of difficulty in going to sleep (8.2) +
- 55. Has feelings of hopelessness (8.2) + +
- 103. Reports difficulty in thinking; can't concentrate (8.2) +
- 8. Overreacts to danger or makes emergency responses in the absence of danger (8.0) +
- 16. Is overanxious about minor matters and reacts to them as if they were emergencies (8.0) + +
- 56. Complains of weakness or easy fatigability (8.0) +
- 68. Keeps people at a distance; avoids close interpersonal relationships (7.8)
- 100. Obsessive thinking is present (7.8) +
- 93. Exhibits manneristic behavior (7.6)
- 18. Is consciously guilt-ridden; self-condemning; self-accusatory (7.4) +
- 40. Genotype has schizoid features (7.4)
- 58. Tends to be ruminative and overideational (7.4)
- 71. Genotype has obsessive-compulsive features (7.4) +
- 86. Is shy, anxious, and inhibited (7.4) +
- 87. Is afraid of emotional involvement with others (7.4)
- 29. Tends to avoid or delay action; fears committing self to any definite course (7.2) +
- 57. Handles anxieties and conflicts by refusing to recognize their presence (7.2)
- 75. Has inner conflict about emotional dependency (7.2)
- 81. Is perfectionistic ; is compulsively meticulous (7.2) +
- 85. Has inner conflicts about sexuality (7.2)
- 66. Is a serious person who tends to anticipate problems and difficulties (7.0) +

Least Descriptive

- 11. Is cheerful (1.0)
- 42. Is "normal," healthy, symptom free (1.0) —
- 107. Would be organized and adaptive when under stress or trauma (1.0) —

- 37. Defenses are fairly adequate in relieving psychological distress (1.4) —
- 49. Appears to be poised, self-assured, socially at ease (1.4) —
- 63. Has a resilient ego-defense system; has a safe margin of integration (1.4)
- 59. Is socially extroverted (outgoing) (1.6) —
- 69. Gets along well in the world as it is; is socially appropriate in own behavior (1.6)
- 4. Has a need to think of self as an unusually self-sufficient person (2.0) —
- 89. Is provocative (2.0) —
- 108. Has the capacity for forming close interpersonal relationships (2.0)
- 39. Genotype has psychopathic features (2.2)
- 51. Exhibits good heterosexual adjustment (2.2)
- 61. Tends to be flippant both in word and gesture (2.2) —
- 25. Presents a favorable prognosis (2.4)
- 23. Judges self and others in conventional terms like "popularity," "social pressures," etc. (2.6)
- 95. Accepts others as they are; is not judgmental (2.6)
- 67. Is able to sense other person's feelings; is an intuitive, empathic person (2.8)
- 3. Values wealth or material possessions and judges others in terms of them (3.0)
- 31. Has a high aspiration level for self; is ambitious; wants to get ahead (3.0)
- 36. Has a rapid personal tempo; thinks, talks, moves at a fast rate (3.0)
- 50. Has a need to affiliate with others (3.0)

2-7-8 See also the 2-7 pattern, point 8, p. 107.

1. This is one of the most frequent profile patterns found in a psychiatric population. Likely long standing distress and obsessional features exist (Lachar, 1984).
2. The person with this pattern has the greatest risk of completing suicide of any other code type (Caldwell, 1985).
3. Gilberstadt and Duker (1965) found this 2-7-844-0-1-3-5-6 pattern in a VA hospital male population. Scales 4, 0, 1, 3, 5, and 6 are elevated above a T of 70, but they are not necessarily the next highest scales in the profile after 2, 7, and S. A man with this pattern tended to be depressed, shy, quiet, withdrawn, and anxious. He usually felt inadequate in all areas of his life. He may have had bizarre thinking and flat affect. The Gilberstadt and Duker book should be consulted for further information concerning

this pattern.

4. Marks, Seeman, and Haller (1974) found this 2-74/8-7-2 pattern in a university hospital and outpatient clinic. A person with this pattern was typically described as tense, anxious, and depressed with confused thinking and much self-doubt. The Marks, Seeman, and Haller book should be consulted for further information concerning this pattern.
5. Kelley and King (1979b) found the 2-7-8/7-2-8 profile in a college mental health clinic. Only males reported difficulty concentrating. They also tended to complain of affective or eating problems. Females with this profile type had many neurotic symptoms. They were tense, nervous, and had respiratory somatic complaints. They also had crying spells, appetite and weight loss, sleep disturbance, fatigue, and feelings of inferiority.
6. For women with a low scale 5 (T = 45 or below), the deep anxieties, depression, study problems, and lack of skills with the opposite sex, seen in the 2-74 pattern are intensified (Drake & Oetting, 1959).

278/728

Persons with this code type are experiencing a great deal of emotional turmoil, and they tend to have a rather schizoid lifestyle. They tend to feel tense, nervous, and fearful, and they have problems in concentrating and attending. They feel depressed, despondent, and hopeless, and they often ruminate about suicide. Affect appears to be blunted or otherwise inappropriate. Eating problems often are reported by women with this code type. These persons lack basic social skills and are shy, withdrawn, introverted, and socially isolated. They tend to be passive in relationships. They feel inadequate and inferior. They tend to set high standards for themselves and to feel guilty when these standards are not met. They tend to show interest in obscure, esoteric subjects. They may use alcohol or other drugs as a way of coping with stress. The diagnostic picture for 278/728 persons is mixed. They may receive either neurotic or psychotic diagnoses. In making a differential diagnosis it often is helpful to try to understand why they have high scores on scale 8. If examination of the Harris-Lingoes subscales indicates that the scale 8 elevation is accounted for primarily by items in the Sc3 (Lack of Ego Mastery, Cognitive) or Sc6 (Bizarre Sensory Experiences) subscales, a psychotic disorder is more likely than if items in the Sc4 (Lack of Ego Mastery, Conative) seem to account for much of the scale 8 elevation.

Diagnosis

Psychosis 58%	Schizophrenic
Psychoneurosis 33%	Anxiety/obsessive-compulsive
Personality disorder 4%-	Schizoid
Brain syndrome 4%	Acute

Personality Description

As befits people with scale 2 so elevated, these patients are depressed. The despondency and pessimism may be expressed in feelings of hopelessness and about 65% of these patients verbalize their suicidal ruminations. The typical

somatic symptoms of weakness and easy fatigability found in depression also occur. However, depression does not occupy the central focus in the total psychological status that it does for either the 2-3-1 or 2-7 types; the picture is more varied and more diffuse. The flow of thought, as revealed in speech, may be disturbed. In our own patient group and in that of Gilberstadt and Duker (1965), these people are frequently termed schizoid or schizophrenic; they seem unable to express their emotions in any modulated or adaptive way. Reports of difficulty in thinking and in concentration are quite common.

Patients with this profile have a long history of personal isolation. One-fourth of them were only children and one-fourth describe their parents attitude toward them as rejecting. There were deaths in the immediate family of 45% of these patients; later, 11% were widowed. Too, there is a trend of physical illness in the parental home of these patients; 15% of fathers and 20% of mothers were not well and 25% of these patients themselves were sickly during childhood.

The 2-7-8 patient is likely to be guilt- and worry-ridden, generally fearful, and vulnerable to minimum threat. What others are likely to view as no more than an

irritant, is usually perceived by them as a major threat. Further, they frequently make emergency responses when no ostensible or "objective" reason can be discerned. Terms often used in describing these patients are tense, nervous, trembling, sweating— all indicators of anxiety or fear. Shy and inhibited are also characteristic descriptive adjectives, with 80% being perceived as withdrawn.

Persons with this profile generally have a long history of poor interpersonal relations. Inner conflicts about emotional dependency are frequent and emotional involvement of any sort poses threats. They withdraw and keep others

at a distance. They perceive themselves as blameworthy people, often express feelings of doubt, self-accusation, and self-condemnation. Sexual conflicts are pervasive and the heterosexual relationships of these patients are notoriously poor; 50% report extramarital relations. Many of the complaints and behaviors associated with scale 7 elevation are reported for these patients. Perfectionistic tendencies and compulsively meticulous behaviors occur. Indecisiveness is characteristic as is the tendency to delay or avoid actions, or to commit oneself to a definite course. Obsessional, ruminative preoccupations are to be expected; these may occur in the form of interest in and exploration of various "philosophic" notions of an unusual or odd sort. Phobias are also commonly encountered in the 2-7-8 profile type. Intellectually, these patients are above average. Their mean IQ obtained on the Shipley is 112 and the mean on the WAIS is 110. This high average intelligence test performance is also consistent with that reported for this code by Gilberstadt and Duker.

Description:

Tense, phobic, depressed, suicidal, psychotic/schizoid reactions/episodes

Modifying Scales

- Typically, Anxiety (ANX) scale is elevated, reflecting the generalized anxiety associated with the code type.
- As a rule, all of the Harris and Lingoes Depression subscales are elevated with this code type, although the relative elevations will predict which aspects of the depression are most salient.
- When Authority Conflict (Pd2) is elevated, look for passive-aggression and acting out as tension and anxiety build.
- When Poignancy (Pa2) subscale is elevated, this will predict even more than the already high interpersonal sensitivity associated with the typical 2-7-8 profile.
- When Lack of Ego Mastery, Cognitive (Sc3) is greater than Mental Dullness (D4), look for more severe cognitive disruption. Extreme elevations on Lack of Ego Mastery Conative (Sc4) (>T-90) would predict severe general inefficiency, even immobilization.
- When Psychomotor Acceleration (Ma2) is significantly elevated, beware of agitation and the energizing effects on suicide threats, especially with energizing antidepressants.

- When Addiction Acknowledgment Scale (AAS) is elevated, beware of addiction proneness and the tendency to use chemical agents as a way of medicating their anxiety.
- Elevations on Antisocial Practices (ASP) may occur in forensic cases where the buildup of severe anxiety and depression led to impulsive acting out. The 2-7-8 code type is not diagnostically pure and may reflect severe depression, a personality disorder (e.g., schizotypal, schizoid, borderline, avoidant, dependent), bipolar disorder, or a schizophrenia spectrum disorder.
- Elevations on Bizarre Mentation (BIZ), Psychoticism (PSYC), or Aberrant Experiences (RC8) scales would suggest either a psychotic depression or schizophrenia spectrum disorder.
- Typically, these individuals score high on Low Self-Esteem (LSE), reflecting their damaged self-esteem; a low score on this scale would be prognostically favorable.
- Feedback with clients whose BIZ, PSY, and or RC8 are elevated would involve discussing with them how confusing the world may be and asking them if they “feel so tense and on edge that they at times wonder what is real” and then asking them to describe experiences that are frightening and confusing. In the presence of psychotic mentation, structure, medication, and minimal insight therapy are recommended until they have stabilized. Feedback should focus on helping them feel safe and validating their current level of anxiety and fear.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Male

Low 0 Introverted or self-conscious or socially insecure, lacks skills with the opposite sex, one interview only, nonresponsive or nonverbal, tense, tense on examinations, indecisive, unhappy, worries a great deal, lacks knowledge or information, vague goals, confused, aggressive or belligerent.

- Note: Scale coded low was infrequently associated with introversion or self-consciousness or social insecurity, lack of skills with the opposite sex, being nonresponsive or nonverbal, indecisiveness, unhappiness, worrying a great deal.

Low 1/3/4/5/6 Introverted or self-conscious or socially insecure, lacks skills with the opposite sex, nonresponsive or nonverbal, tense, tense on examinations, indecisive, unhappy, worries a great deal, lacks knowledge or information, vague goals, confused.

Low 9 Introverted or self-conscious or socially insecure, lacks skills with the opposite sex, generally dependent, nonresponsive or nonverbal, tense, tense on examinations, indecisive, unhappy, worries a great deal, lacks knowledge or information, vague goals, confused.

Nothing Low Introverted or self-conscious or socially insecure, lacks social skills, lacks skills with the opposite sex, home conflict, mother conflict, sibling conflict, nonresponsive or nonverbal, tense, tense on examinations, indecisive, unhappy, worries a great deal, insomnia, lacks knowledge or information, vague goals, confused

Female

Low 0 Anxieties, depressed, insomnia, nervous, lacks self-confidence, distractible in study, tense on examinations, socially insecure, socially shy, lacks skills with the opposite sex, 4 to 7 conferences, verbal.

- Note: Scale coded low was infrequently associated with depression, lack of selfconfidence, social insecurity, social shyness, lack of skills with the opposite sex.

Low 1 Anxieties, depressed, insomnia, nervous, lacks self-confidence, physical inferiority, distractible in study, socially insecure, socially shy, lacks skills with the opposite sex, 4 to 7 conferences.

Low 3 Anxieties, depressed, insomnia, nervous, lacks self-confidence, distractible in study, socially insecure, socially shy, lacks skills with the opposite sex, 4 to 7 conferences, cried in the interview.

Low 4 Anxieties, depressed, insomnia, nervous, lacks self-confidence, distractible in study, socially insecure, socially shy, lacks skills with the opposite sex, 4 to 7 conferences.

Low 5 Anxieties, depressed, insomnia, nervous, headaches, exhaustion, lacks self-confidence, indecisive, distractible in study, tense on examinations, socially insecure, socially shy, lacks skills with the opposite sex, 4 to 7 conferences, wants answers.

Low 6 Anxieties, depressed, insomnia, nervous, lacks self-confidence, distractible in study, socially insecure, socially shy, lacks skills with the opposite sex, 4 to 7 conferences, nonverbal.

Low 9 Anxieties, depressed, insomnia, nervous, lacks self-confidence distractible in study, socially insecure, socially shy, lacks skills with the opposite sex, 4 to 7 conferences, mother conflict.

Nothing Low Anxieties, depressed, insomnia, nervous, exhaustion, headaches, lacks self-confidence, distractible in study, socially insecure, socially shy, lacks skills with the opposite sex, 4 to 7 conferences (27), 8+ conferences (28, 8-X), father conflict, mother conflict, sibling conflict.

(Drake & Oetting, 1959)

o **Check:** *ANX, FRS1, OBS, DEP, DEP1, DEP2, DEP3, DEP4, Hp, RC2, RC7, CogProb, DisOrg, HEA1, HEA2, HEA3, BIZ1, BIZ2, ANG1* (low), *CYN2* (low), *TPA2* (low), *LSE1, LSE2, SOD1, WRK, AGGR* (low), *PSYC, NEGE, Dr1, Dr2, Dr3, Dr4, Dr5, Hy1* (low), *Hy3, Hy4, Pd2* (low), *Pd4, Pd5, Pa1, Pa2, Sc1, Sc2, Sc3, Sc4, Sc5, Sc6, A, Es, MAC-R* (low), *Re, MDS*.

TREATMENT

This codetype predicts a pervasive unhappiness and anhedonia, though palpable sadness may not be apparent to the therapist because the 278 presents as flat, almost emotionally numb, and disconnected. Because they see every side of an issue, they are highly ambivalent, and often immobilized by even small decisions. This can lead to “analysis paralysis” without any real behavioral change. Continual blunting of expressions of affect, along with difficulty dealing with emotional intimacy, leads them to have relationship problems. The observing ego tends to control them because they are so painfully self-conscious. Consequently, Gestalt therapies are particularly useful because the role-playing involved provides an opportunity for the patient to vent feelings. Taking an acting class that allows them to feel, but “feel through” somebody else’s eyes may give them some relief from bottled up feelings and feelings of depersonalization. They fear being “in the moment” because they anticipate that switching off the observing ego will lead to unpredictable, humiliating emotional abandonment. They have a fixed, negative self-image, which makes therapy difficult. Introspective insight therapies are contraindicated because of the 278 individual’s tendency to intellectualize. Look for childhood experiences of feeling overwhelmed by panic anxiety with the absence of a reliable caretaker. In some cases, sexual abuse and emotional and physical abandonment are associated with this codetype. Many 278 individuals have been “only” children. Thirty-five percent of the Marks et al. (1974) sample reported deaths in the immediate family, and many reported a serious physical illness in their childhood home; 15 percent of fathers and 20 percent of mothers were sick, and 25 percent of 278s reported serious illness during their childhood. It is understandable that, as an adaptive response, they became constantly on edge, scanning the environment for danger, preparing “for the other shoe to drop.” The constant edgy vigilance tends to exact a toll on their immune systems. Interestingly, 50 percent of the Marks et al. (1974) sample reported extramarital relationships. These individuals tend to be as critical of their spouses as they are of themselves, reflecting their low self-esteem. Assertiveness training, self-esteem building, and warm, supportive, motherly type reparenting therapies can be useful therapeutic modalities. Many individuals with this codetype are diagnosed as borderline, especially when Scale 4 is elevated, but diagnoses of endogenous depression, both unipolar and bipolar, and undifferentiated schizophrenia are also common. They typically develop peculiar and esoteric personal philosophies, perhaps as a way of finding unique meaning in their lives.

o **Treatment:** Rule out Bipolar Disorder, Depressed; Schizophrenia, Undifferentiated; Schizoaffective Disorder. Biological treatments more immediately effective than psychotherapy to improve symptomatic status and reduce suicide risk. Some risk of antidepressants precipitating mania. More accepting of structure and support, less well defended but less defensive, more access to insight, and more cognitively resourceful than 2-8/8-2. Supportive

and cognitive therapies are effective in the postacute phase. Need direction as well as support. Better overall outcomes than 2-8/8-2.

Therapy and Therapeutic Pitfalls

Clients with this profile tend to gravitate toward traditional insight-oriented therapies because they are overanalytical and afraid of the loss of control involved in cathartic therapies. They replicate their childhood–parent dynamics with their therapists by expecting to be emotionally bullied and criticized and anticipating therapist impatience and rejection. At the same time, they have difficulty expressing their feelings, especially anger, toward the therapist. The therapist may experience frustration, as these clients will express emotions in passive and self-defeating ways. It is frightening for them to express an emotion openly and directly, perhaps reflecting their early conditioning experiences of a critical rejecting parent figure. However, real therapeutic change is facilitated when they learn to recognize and express their emotions in a direct way. Gestalt therapies (Fagan & Shepherd, 1970) that have clients role play can help them learn to “feel” their emotions. Dealing with transference and countertransference can increase their awareness of their tendency to personalize. Long-term therapy involves reparenting in a supportive and nurturing manner, by teaching them to trust enough to express and negotiate their wants.

Therapist warmth, openness, and willingness to engage rather than the traditional distant therapeutic relationship appear helpful in long-term therapy. Insight therapy can be useful as a tool to help them develop a sense of empathy for themselves. Short-term therapy should focus on self-esteem building, thought stopping, cognitive restructuring, and rational emotive therapy. Concrete homework exercises can foster a sense of empowerment with the 2-7-8. It is important to avoid rescuing these clients, but at the same time it is important to be supportive and encouraging. Progress can be made if therapists occasionally are open to admitting to their own human failings, expressions of irritation, and other vulnerabilities as a way of validating the clients’ experiences in therapy and allowing them to feel some sense of equality.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Treatment and Self-Help Suggestions

1. Work with your therapist to develop thought-stopping techniques so that you can slow your mind down.¹ Recognize when your mind is racing so that you can learn to slow it down and focus on one thing at a time. Thought stopping is an effective technique you can practice to help you prevent the types of unwanted thoughts that can make you feel anxious. Several forms of thought stopping are effective. One quick technique involves picturing or saying out loud, “Stop,” whenever you experience these types of unwanted

thoughts. You then replace the thought with a pleasant image or affirmation that is more positive (e.g., “I have felt this way before, and I know I can handle this”).

2. Discuss with your therapist specific childhood events where you felt put down, humiliated, rejected, or abandoned so that you can better understand how you developed these fears. Revisit some of these painful events with your therapist, learning to have empathy for yourself. Role play being the nurturing supportive parent to yourself as a child. It may help to bring in your childhood photos so you can recall what it felt like and then can practice self-soothing.
3. People with your profile do well if they can exercise on a regular basis. It helps control anxiety.
4. Avoid using drugs and alcohol as a way of relaxing, as they can be addictive and actually aggravate your anxiety and depression over the long run.
5. Resilience building: Work with your therapist to identify your positive traits and “signature strengths.”² Write them in a list, and read them every day. Work with your therapist to find new ways to use your signature strengths.
6. Whenever you find yourself ruminating or obsessing about how someone has hurt you, assert yourself and express what you are feeling. Don’t be afraid to be more assertive.
7. Whenever you make a demand on others or assert yourself, be aware that you immediately feel guilty. Work on switching off the guilt, as it reflects your fear that if you make a demand on others they will reject you.
8. Resilience building: Because you tend to anticipate the worst and have a sense of impending disaster, keeping a daily “gratitude journal” can help instill a sense of hope and can help to replace some of your negative thinking.³
9. Inspire yourself. Carry something positive (e.g., a poem, picture of a loved one) and use it to remind yourself of positive things in your life.
10. When you can, choose self-respect. Do things that will make you feel good about yourself. When things go wrong, talk to yourself in a soothing way as you might to a dear friend or vulnerable child.

11. When things go wrong, you tend to blame yourself. Whenever things go well, you tend to see it as due to others or to luck. On a daily basis keep a diary of things that go well, and see how you contributed to the positive outcome.

¹ *Mind Over Mood* (Greenberger & Padesky, 1995). This workbook contains exercises such as thought stopping and keeping a thought record to overcome negative and destructive thinking.

² Signature strength exercise: After identifying five signature strengths (Peterson, Park, & Seligman, 2005) clients are asked to use one of these strengths in a new and different way every day for 1 week. In a study comparing 70 people in a placebo control group and 66 subjects who completed the Signature Strength Exercise, those who adhered to the exercise experienced a significant decrease in depression and a significant increase in happiness both post study and at a 6-month follow-up (Seligman, Steen, Park, & Peterson, 2005).

³ Compared with subjects who journaled about neutral events or recorded “daily hassles,” people who kept gratitude journals felt better about their lives in general and were more optimistic about the upcoming week (Emmons & McCullough, 2003).

(Levak, Siegel, Nichols, & Stolberg, 2011)

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you are a very analytical individual. You tend to go through life constantly observing, as if watching yourself in a movie. It is hard for you to turn off your observing self to be spontaneous and in the moment because you're always waiting for something bad to happen. It is similar to a computer freezing because too many windows are open simultaneously. The profile suggests that you are going through life as if you have “too many windows” open inside your mind, so you're seeing every side of every issue. It is as if you can't allow yourself a single train of thought without being interrupted by many competing thoughts. It is hard for you to relax and to enjoy being in the moment. It is also hard for you to enjoy your accomplishments as you are always ready to be your own worst critic. This is exhausting and leaves you feeling depressed, sad, and hopelessly defeated. Making decisions is difficult because you see all the things that could possibly go wrong so that often, even though you're anxious and worried, you can be highly inefficient and get little done. Getting going and feeling motivated is difficult. Growing up you may have felt unsafe, perhaps because of parental illness or because your parents could be unpredictably cold and emotionally withdrawn. To adapt, you developed a constant vigilance for what can go wrong, and were constantly self-critical, to make sure you never took anything for granted. It is as if you protect yourself

against ever getting hopeful and enjoying the moment, because to do so would risk getting disappointed. Your therapist may suggest medication to help you sleep better, to feel more energized and rested, and help you to concentrate and think more clearly.

Develop some empathy for yourself as a child who felt overwhelmed. Learn to switch off guilty thoughts and learn ways to assert yourself, asking for what you want even though you may often be confused about your own wishes. Talk to your therapist about how you feel toward him or her and discuss how hard it is for you to switch off the part of you that is always observing and self-critical, and expecting your therapist to be critical of you.

Feedback Statements—Elevated Profiles (T-Score > 65)

Anxiety, Fears, Phobias

The profile suggests that you are feeling quite anxious and on edge much of the time. Even when things are going relatively well, you may have a nagging sense of anxiety without really knowing where it's coming from. You may experience feelings of fear as well as anxiety, and you may find yourself worrying about specific things that could possibly go wrong. In some cases, people with your profile have specific phobias of driving or of being sick, damaged, or defective. You may find yourself worrying that there is something deeply wrong with you, perhaps that your physical health is somehow damaged or that your body will let you down.

Depression or Anhedonia

People with this profile often feel sad and depressed. Sometimes the depression is the result of being worn out by constant worrying and anxiety. In other cases, depression is more prominent than anxiety. It may be hard for you to enjoy life, even when things are going well and you “should be” enjoying it. You likely find it hard to experience joy or positive emotions, so that nothing seems pleasurable. We call this anhedonia. Even in moments when you know you should be experiencing pleasure, you can't seem to feel it. This can be disturbing and perhaps makes you feel that you are somehow different, defective, or broken. Anhedonia is a symptom of the kind of depression you're experiencing.

Difficulties With Memory and Concentration

People with your profile often experience difficulties with concentration and memory. Because you may feel agitated and self-critical and because your mind is distracted and easily interrupted with thoughts of disaster, it's hard to keep your mind on task. Because it's hard to focus when someone is talking to you or when you're reading, it becomes hard to remember things. It's hard for you to “log in” information because your mind is distracted and interrupted

by negative thoughts; sometimes people with your profile feel so “foggy” in their ability to think and recall that they worry there is something wrong with their mind.

Difficulties With Sleep or Fatigue

You may find that your sleep is disturbed. Some people with this profile find it very hard to get to sleep because of their racing thoughts or a constant sense of dread and anxiety. In other cases, people with your profile can get to sleep, sometimes out of sheer exhaustion, but then wake up startled at 2 or 3 in the morning, with a sense of dread and anxiety and feel fatigued much of the time.

Somatic Complaints

Because you feel keyed up, tense, and anxious, and because you are on edge waiting for something bad to happen, your body may experience a great deal of stress. People with your profile often complain of headaches, backaches, stomach upsets, and other vague and shifting physical complaints that may reflect your extreme internal tension.

Psychotic Thoughts

Sometimes people with your profile feel so exhausted and depleted by their anxiety and by the depression that they actually begin to distort reality. You may wonder if you are hearing people call your name or if people are talking about you. This is often the result of a severe depression. If this applies to you, you may find yourself wondering if people are saying cruel and mean things about you or thinking that people want to harm you because you feel undeserving of love and support. Though people with this profile rarely experience this severity of depression, when it does happen it can be disturbing and frightening.

Feeling Inferior, Damaged, Unlovable

It's easy for you to feel that you're not as good as others. Even when people like you, you tend to dismiss it; if people give you compliments, you feel awkward and undeserving. Even when you have a success, you doubt yourself. You dismiss your achievements as somehow accidental and not the result of your efforts and abilities. People with your profile can feel defective and damaged, and that there is something fundamentally wrong with them. They often feel unloved and unlovable. In fact, when others express love and admiration for you, you may feel that you have somehow fooled them. Praise can make you uncomfortable.

Self-Defeating or Suicidal

Sometimes people with this profile are self-defeating, giving up easily even when progress is being made. Sometimes you may be self-defeating by allowing others to push you to actions you feel are bad for you. In other situations you might not ask for what you want, so you miss out on opportunities. In some cases people with this profile feel so bad that they fantasize or even plan suicide as a way of escaping the pain. This would be important to share with your therapist.

Compulsive, Perfectionist, Procrastinating

Sometimes people with your profile develop compulsions, which are drives to engage in certain habits or behaviors. You might develop superstitions and compulsions as a way of calming your anxiety. Some people develop particular rituals and habits that initially made sense as a way of reducing anxiety but that, over time, appear eccentric and can cause even more anxiety and guilt. You may be perfectionistic and self-critical so new tasks and activities are stressful because they provide just another opportunity to fail. You may procrastinate yet feel guilt in doing so.

Lifestyle and Background Feedback

Typically, people with your profile had childhoods in which they felt anxious and insecure. Perhaps your parents were both very controlling and protective yet somehow demeaning, leaving you feeling put down and lacking the necessary confidence to deal with life. You may have been a sensitive child who disliked new situations, or you may have matured more slowly than your peers. This may have led to your parents protecting you without helping you develop the sense of control and confidence that you needed. It's also possible that you were overloaded with too many tasks and responsibilities, perhaps because your parents were not available, leaving you anxious and insecure because the demands on you were unreasonable.

Normal-Range Feedback

Your scores are in the normal range and suggest that you are responsible but prone to worry. You are a perfectionist who is organized and focused on details, though you may have a tendency to procrastinate because you are worried that you might somehow fail. Although you have many healthy strengths, you might sometimes feel that you are not quite "good enough," and if people give you compliments you may feel that you don't deserve them. You are likely to be your own worst critic, and you can be self-deprecating and self-effacing, perhaps as a way of preempting criticism or judgment from others. Your self-consciousness and fear of others' judgment make it hard for you to be spontaneous and "in the moment."

(Levak, Siegel, Nichols, & Stolberg, 2011)

1. In this combination the 0 scale is elevated, but it is not necessarily the next highest scale after 0. For people with this pattern there usually is chronic depression, introversion, and shyness (Caldwell, 1972).
2. Over a period of time, the psychomotor responses in these clients may slow up. The clients appear to have mood swings, but in reality they have been steadily slowing down with occasional bursts of energy (Caldwell, 1972).
3. This person may report waking early in the morning (Caldwell, 1972).
4. He/she usually is negative concerning his/her achievements (Caldwell, 1972).
5. A person with this profile is a problem in therapy. He/she tends to intellectualize endlessly (Caldwell, 1972).
6. A person with this profile may report incidents of teasing in early childhood. The person may feel that he/she is the inferior member in the family (Caldwell, 1972).

279 Code

Male

Low 0 Home conflict, one interview only, tense, tense on examinations, indecisive (27), imhappy, worries a great deal, lacks knowledge or information, aggressive or belligerent, rationalizes a great deal, defensive.

- Note: Scale coded low was infrequently associated with indecisiveness, unhappiness, worrying a great deal; Scale 9 coded high was infrequently associated with worrying a great deal. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, shyness in the interview, being nonresponsive or nonverbal, being nonverbal or a nonrelator, indecisiveness (9-0).

Low 1 Home conflict, nonresponsive or nonverbal, tense, tense on examinations, indecisive, imhappy, worries a great deal, confused, aggressive or belligerent, rationalizes a great deal, defensive.

- Note: Scale 9 coded high was infrequently associated with being nonresponsive or nonverbal, indecisiveness, worrying a great deal.

Low 1/3/5/6/8 Home conflict, tense, tense on examinations, indecisive, imhappy, worries a great deal, aggressive or belligerent, rationalizes a great deal, defensive.

- Note: Scale 9 coded high was infrequently associated with indecisiveness and worrying a great deal.

Nothing Low Introverted or self-conscious or socially insecure, lacks social skills, lacks skills with the opposite sex, home conflict, mother conflict, sibling conflict, nonresponsive or nonverbal, tense, tense on examinations, indecisive, unhappy, worries a great deal, insomnia, confused, aggressive or belligerent, rationalizes a great deal, defensive.

- Note: Scale 9 coded high was infrequently associated with lack of skills with the opposite sex, being nonresponsive or nonverbal, indecisiveness, worrying a great deal.

Female

Low 0 Anxieties, depressed, nervous, exhaustion, lacks self-confidence, confused, distractible in study, tense on examinations, marriage oriented, socially insecure (29, 27), socially shy (27), socially extroverted (9-0), 4 to 7 conferences, verbal, sibling conflict.

- Note: Scale coded low was infrequently associated with depression, exhaustion, lack of self-confidence, confusion, social shyness, social insecurity, sibling conflict.

Low 1 Anxieties, depressed, nervous, lacks self-confidence, confused, physical inferiority, distractible in study, vague goals, socially insecure (29, 27), socially shy (27), socially extroverted (9-1), 4 to 7 conferences, sibling conflict.

Low 3 Anxieties, depressed, nervous, lacks self-confidence, confused, distractible in study, vague goals, socially insecure, socially shy, 4 to 7 conferences, cried in the interview, sibling conflict.

Low 4 Anxieties, depressed, nervous, lacks self-confidence, confused, distractible in study, socially insecure, socially shy, shy in the interview, 4 to 7 conferences, nonresponsive, sibling conflict.

- Note : Scale 9 coded high was infrequently associated with shyness in the interview.

Low 5 Anxieties, depressed, nervous, headaches, insomnia, exhaustion, lacks self-confidence, confused, indecisive, distractible in study, tense on examinations, socially insecure, socially shy, lacks skills with the opposite sex, 4 to 7 conferences, wants answers, verbal, sibling conflict.

Low 6 Anxieties, depressed, nervous, lacks self-confidence, confused, distractible in study, socially insecure, socially shy, 4 to 7 conferences, nonverbal, sibling conflict.

Low 8 Anxieties, depressed, nervous, lacks self-confidence, confused, distractible in study, socially insecure, socially shy, 4 to 7 conferences, sibling conflict.

Nothing Low Anxieties, depressed, nervous, headaches, lacks self-confidence, confused, distractible in study, socially insecure, socially shy, lacks skills with the opposite sex, 4 to 7 conferences, sibling conflict.

(Drake & Oetting, 1959)

Code-Type 2-8/8-2

Descriptors

Complaints

Severe depression, anhedonia, sleep problems, memory or concentration difficulties, appetite disturbance, sexual difficulties, apathy, anxiety, slowed pace, reduced efficiency, somatic complaints, socially withdrawn

Thoughts

Concentration or memory difficulties, impaired decision making, morbid ruminations, self-loathing, somatic preoccupations, tangential thinking or possible thought disorder, suicidal thoughts

Emotions

Blunted/inappropriate affect, deep pessimism, feelings of worthlessness, helplessness, guilt, depersonalization, derealization, irritable, resentful

Traits and Behaviors

Socially withdrawn, fear of social interaction, passive, fear of emotional closeness, underachieving, possible suicide attempts

(Levak, Siegel, Nichols, & Stolberg, 2011)

Therapist's Notes

The 2-8 code type in the normal range suggests a mild, anxious depression in alienated and emotionally disconnected individuals. Poor self-esteem, difficulties with empathy, and a tendency to withdraw under stress are suggested. When elevated, the profile reflects a severe depression that is experienced as a frightening loss of cognitive ability. Severe difficulties with concentration, memory, decision making, and general efficiency are present. Schizotypal personality features may also be present. The existential experience of these clients is a deep sense of hopelessness and pessimism together with feelings of being broken, defective, and unlovable. They complain that

their mind is “foggy,” feel easily confused, and experience diffuse panic that lacks concrete content. Ruminative and obsessive, they are highly inefficient and unable to “get going,” even when tasks are simple and routine. They feel as if they are in a semifugue state, unable to recall recent behavior or decisions. They experience a great deal of anxiety and often ruminate about the possibility that they have some kind of brain disorder. This reflects the severity of the cognitive impairment associated with this depression. The depression is qualitatively different from a 2-7-8 depression. In a 2-7-8 depression, clients experience internal conflict and poor self-esteem, but the elevation of Scale 7 suggests a drive toward connection with others and attempts to resolve internal discomfort. The 2-8 individuals, however, manifest apathy, blunted or inappropriate affect, and a diffused sense of anxiety that is associated with the feeling of being hopelessly broken. In some cases, the severity of depression may be masked because they appear flat, apathetic, unflappable, and withdrawn, with little variation in tone and emotional expression. They have a negative self-image, and, not surprisingly, they show poor judgment and exhibit general inefficiency. Making simple decisions can be enormously taxing because they are unable to maintain the relevant threads involved in complex decision making. These clients experience strong feelings of vague and pervasive guilt and self-loathing. They are very socially withdrawn, actively avoiding others, and they have strong fears of emotional closeness. They mistrust others, perceiving relationships as potentially dangerous and almost always painful for them. Although they may experience irritability and impatience, it is more self-protective than aggressive. In some cases, the profile reflects a psychotic depression with anxiety, confusion, tangential thinking, and delusions. The 2-8 code type is associated with individuals who have experienced a brain injury. In other cases, a 2-8 may reflect the depressed phase of a bipolar disorder or a chronic depressed, marginally adjusted lifestyle. Suicidal thoughts are likely, and threats should be taken seriously, as a 2-8 can often lose the will to live. Beware of energizing antidepressants such as selective serotonin reuptake inhibitors (SSRIs), as they can activate these individuals’ suicidality. Initially, individuals of code-type 2-8 appear almost bland, and the therapist may miss the severity of the depression. It’s as if they no longer complain about their symptomatology, but rather feel resigned to a life of marginal existence and isolation from others.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Lifestyle and Family Background

We hypothesize that the 2-8 profile is an adaptation to childhood experiences of cruel neglect. Look for mentally ill parents who were unable to provide basic emotional nurturance and support or for a childhood in which they felt neglected and ignored in ways that felt cruel and identity damaging. One 2-8 client reported that her father had been schizophrenic, and the family lived on a farm with few corrective social experiences to make up for the bleakness

of her childhood environment. She reported that her father would often stare at her, seeing through her, almost as if she didn't exist. She could be deeply upset about some event, and he would walk past her, ignoring her anguish.

The type of identity damage that the 2-8 individuals experience involves feeling broken, defective, and hopelessly unlovable. Their response to parental hostile neglect is to withdraw into fantasy, to shut down emotional involvement, and to reduce any drive for emotional nurturance and social connection.

It would make adaptive sense for individuals to withdraw and extinguish the drive for interpersonal interaction in the face of what they perceive as overwhelming rejection and disdain. Sometimes the precipitating event for the current depression is the withdrawal of a previously supportive or loved object. This then reactivates the scar tissue of early emotional neglect and feelings of hopeless defectiveness. In other cases, the profile may reflect some recent physical injury or trauma that activates in the clients' fears that they are somehow hopelessly broken or damaged. In the absence of a history of withdrawal, marginal social adjustment, and bouts of incapacitating depression, the 2-8 profiles may reflect a recent reactive depression.

(Levak, Siegel, Nichols, & Stolberg, 2011)

This codetype reflects severe depression, social withdrawal, and agitation, difficulties with concentration, thinking, and memory, and preoccupations with being hopelessly damaged. Sometimes this profile reflects a psychotic depression. A primary complaint for the 28/82 individual is forgetfulness and difficulties with concentration, with some reporting fears that they are "losing their mind." Cognitive impairment due to depression is often the primary complaint.

These individuals seem tense and jumpy, and they keep others at a distance. They are highly inefficient in making and carrying out plans, and may develop peculiar esoteric beliefs. Suicidal thoughts are likely. 28 individuals are extremely fearful of interpersonal intimacy and many report somatic symptoms. Problems with sleep and being easily fatigued are typical. These individuals have conflicts about emotional dependency and sexuality.

o Similar to 2-7-8/2-8-7/7-2-8/7-8-2/8-2-7/8-7-2. Severe depression with suicidal ideation, anhedonia, apathy, blunted or inappropriate affect, anxiety, psychomotor retardation, pessimism, agitation, and fixed negative self-concept. Convictions of worthlessness, hopelessness, and helplessness. Severe impairment in concentration (often with intrusive ideation), memory, judgment, thinking, and decision making, and chronic feelings of inadequacy and inferiority. Thinking is ruminative, stereotyped, and unproductive, and efficiency is markedly reduced, often to the point of disability. Feelings of guilt may be accompanied by much self-blame and self-loathing. Vegetative signs of depression, somatic delusions, nihilistic delusions, derealization, and schizotypal features may be present. Socially withdrawn; actively avoids/discourages interaction; fears emotional closeness; is mistrustful, irritable, impatient, and

resentful toward others. May be viewed as markedly incompetent (e.g., accident prone) and quick to give up. Acting out and problems with impulse control not uncommon. Look for manifest psychotic ideation, thought disorder, confusion, tangentiality, hallucinations, and delusions of persecution and control (especially with Scale 6 third highest), substance abuse, and history of academic underachievement, family conflict/ estrangement, previous suicide attempts, and psychiatric hospitalizations. $2 > 8$ more common in depression; $8 > 2$ more common in schizophrenia.

- o Anxious, agitated, tense, jumpy; sleep disturbance, inability to concentrate, forgetfulness, confused thinking; inefficient in carrying out responsibilities; unoriginal and stereotyped in thinking and problem solving; somatic symptoms; underestimates seriousness of problems; unrealistic self-appraisal
- o Dependent, unassertive; irritable, resentful; fears loss of control and doesn't express emotions; denies impulses, dissociative periods of acting out may occur; sensitive to reactions of others; suspicious of motivations of others; history of being hurt emotionally and fear of being hurt more; avoids close interpersonal relationships; feelings of despair and worthlessness
- o Suggestive of serious maladjustment (especially if both scales are grossly elevated); most common diagnoses are manic-depressive psychosis, involutional melancholia, and schizophrenia, schizoaffective type; chronic, incapacitating symptomatology; guilt-ridden; clinically depressed; soft and reduced speech, retarded stream of thought, tearfulness; apathy, indifference; preoccupation with suicidal thoughts, and may have specific plan for doing away with self

This high point pair suggests depression with accompanying anxiety and agitation leading to a fear of loss of control of hostile and aggressive impulses. Suicidal ideation is likely and the potential for self-destructive behaviors is high. Individuals with this high point pair exhibit a marked psychological deficit as evidenced by a general loss of efficiency, periods of confusion, a retarded stream of thought, a stereotyped approach to problem solving, and noticeable difficulties with concentration. Occasionally, the clinical picture may include hysterically determined somatic symptoms of an atypical variety. Unlike the hysteric, however, individuals with this high point pair are typically unsociable, interpersonally sensitive, and suspicious. They complain of concentration and thinking difficulties and may show a formal thought disorder consistent with a schizophrenic disorder. The potential inherent

in the intimacy for subsequent rejection results in their reluctance to become involved with others. This lack of meaningful involvement increases their feelings of despair, worthlessness, and low self-esteem. Individuals with this high point pair typically have a chronic level of adjustment that is of marginal quality; therefore, the prognosis for intervention and subsequent change is poor. Most individuals with this high point pair receive a diagnosis of either major depression, schizophrenia, or schizoaffective disorder.

Symptoms and Behaviors

Persons with the 28/82 code complain of depression, anxiety, insomnia, fatigue, and weakness, as well as mental confusion, memory impairments, and difficulties in concentrating. They may also feel withdrawn, alienated, agitated, tense, and jumpy. Their motivation to achieve is characteristically low, as is their overall level of efficiency. They are likely to be unoriginal, stereotyped, apathetic, and indifferent. Often, they will have fears relating to an inability to control their impulses, including suicide. They are suspicious and extremely sensitive to the criticisms of others. Delusions and hallucinations may also be present, especially if Scale 8 is greater than 85. This list of complaints presents a highly diverse description of attributes, only some of which may be present in any specific case. The presence or absence of these complaints must be determined by examining data other than mere scale elevations. This may include the investigation of critical items, clinical interview data, personal history, and the use of the Harris-Lingoes and content scales (particularly BIZ/Bizarre Mentation, FRS/Fears, OBS/Obsessions, LSE/Low Self-Esteem, and SOD/Social Discomfort). Differential diagnosis can be extremely important to determine. Most persons with this code type are diagnosed as having a major affective disorder (bipolardepressed or major depression). Schizophrenia or schizoaffective disorder is also a possibility. Personality disorders might include borderline, avoidant, obsessive-compulsive, or schizoid. These personality patterns might feature lability, emotional instability, and acting out.

Personality and Interpersonal Characteristics

Relevant personality descriptors include resentful, unassertive, dependent, and irritable. They often feel excessive guilt and are self-punitive. They justifiably have a fear of losing control of their emotions. A typical coping strategy is to deny unacceptable impulses, but this sometimes results in dissociative periods of acting out.

28/82

Persons with the 28/82 code type report feeling anxious, agitated, tense, and jumpy. Sleep disturbance, inability to concentrate, confused thinking, and

forgetfulness also are characteristic of 28/82 people. Such persons are inefficient in carrying out their responsibilities, and they tend to be unoriginal in their thinking and problem solving. They are likely to present themselves as physically ill, and somatic complaints include dizziness, blackout spells, nausea, and vomiting. They resist psychological interpretations of their problems, and they are resistant to change. They underestimate the seriousness of their problems, and they tend to be unrealistic about their own capabilities. 28/82 individuals are basically dependent and ineffective, and they have problems in being assertive. They are irritable and resentful much of the time; they fear loss of control and do not express themselves directly. They attempt to deny undesirable impulses, and cognitive dissociative periods during which negative emotions are expressed may occur. Such periods are followed by guilt and depression. 28/82 persons are rather sensitive to the reactions of others, and they are quite suspicious of the motivations of others. They may have a history of being hurt emotionally, and they fear being hurt again. They avoid close interpersonal relationships, and they keep people at a distance emotionally. This lack of meaningful involvement with other people increases their feelings of despair and worthlessness.

If both scales 2 and 8 are very elevated, the 28/82 code type is suggestive of serious psychopathology. The most common diagnoses given to psychiatric patients with this code type are bipolar disorder and schizoaffective disorder. 28/82 individuals have chronic, incapacitating symptomatology. They are guilt-ridden and appear to be clinically depressed. Withdrawal, flat affect, soft and reduced speech, retarded stream of thought, and tearfulness also are common. Psychiatric patients with the 28/82 code type may be preoccupied with suicidal thoughts, and they may have a specific plan for doing away with themselves.

1. A person with this profile tends to be withdrawn because of feelings of worthlessness.
2. He/she tends to have severe depression with anxiety and agitation and a fear of loss of control (Lachar, 1974).
3. The individual is usually confused and may have difficulty concentrating.

4. He/she also tends to be agitated, tense, and inefficient. Such persons are likely to say they are physically ill and have such symptoms as dizziness, blackouts, nausea, and vomiting (Graham, 1977).
5. Usually a history of repeated hurts in childhood exists. The person now fears being hurt more and therefore runs from closeness (Caldwell, 1972).
6. Caldwell (1985) has found that if the 4 scale is not significantly elevated, psychotropic medicines work well with these people. If the 4 scale is also elevated, people do not respond well.
7. If both scales are highly elevated, this combination may indicate serious pathology.
8. Marks, Seeman, and Haller (1974) found the 24/8-2 pattern in a university hospital and outpatient clinic. People with this pattern were usually anxious, depressed, and tearful. They tended to keep people at a distance and were afraid of emotional involvement. They tended to fear loss of control and reported periods of dizziness and forgetfulness. The Marks, Seeman and Haller book should be consulted for further information concerning this profile.
9. Gynther, Altman, and Sletten (1973) and Warbin, Altman, Gynther, and Sletten (1972) also found that psychiatric inpatients with this 2-8/8-2 pattern showed symptoms of depression such as suicidal thoughts or attempts. The suicidal ideation may be in the form of a specific plan. For this code type, different diagnostic implications are associated with the 2-8 and the 8-2 codes.
 - a. With a 2-8 profile, somatic delusions may be present.
 - b. For the 8-2 profile, one or more symptoms of schizophrenia, i.e., hallucinations or delusions of persecution, may be present.
10. However, Lewandowski and Graham (1972) have found that patients with this pattern in comparison to other patients tend to be more grandiose and less likely to be anxious or to say they feel blue or depressed.
11. Adolescents in treatment with the 24/8-2 pattern (Marks et al., 1974) were referred to therapy because of being emotionally inappropriate. They were also nervous, anxious, and timid. They appeared fearful of emotional involvement and had inner conflicts about sexuality and emotional dependency. Almost half of these adolescents had made suicide attempts. They were frequent truants. The Marks, Seeman, and Haller

book should be consulted for further information concerning this profile.

12. Kelley and King (1980) found the 2-8/8-2 profile in a college client population. These people had disruptive thoughts, and social withdrawal. They tended to be diagnosed as schizophrenic. Females had more affective features and were diagnosed schizoaffective. They also abused many types of drugs. Males were more flat and apathetic and had more somatic symptoms and motor peculiarities such as tics.

Diagnosis

Psychosis 70%+ Schizophrenic/schizo-affective

Brain syndrome 15%+ Acute

Psychoneurosis 10% Mixed

Personality disorder 5% Schizoid

Personality Description

Patients with this code are manifestly depressed individuals who are likely to express their sadness and despondency in open tearfulness. About half the patients with this profile report suicidal thoughts and 15% make threats, although nowhere near that proportion carry such thoughts and threats into action. Disturbance of sleep is part of the depressive component of the psychological picture, as is the retarded stream of thought. While some of these patients are diagnosed as suffering from involutional depression, a diagnosis of schizophrenia is far more common; 70% are judged to be psychotic and another 15% are classified as organic brain syndrome.

The expression of psychological conflict through somatic channels is encountered frequently among patients generating this profile. Often, they view their problems and their disorder as "being physically ill" and they are quite defensive about admitting any possible psychological component. Typically they experience dizziness, blackout spells, nausea, and vomiting. Warbin^a. (1972) report somatic delusions among their 2-8 sample.

The avoidance of close interpersonal relationships is a cardinal characteristic of these patients, the majority of whom come from "broken" homes; they strive

to keep people at a distance. Involvement of any intimate sort with others is threatening, yet 70% are married; it is interesting to note that 45% of those married report a courtship period of 1 week or less. Others are likely to be regarded by the 2-8 patient with mistrust and their motivations are likely to be questioned. Conflict about emotional dependency is probable, as is inner conflict about sexuality. A generally irritable and resentful manner or tone is also characteristic of 2-8 patients. Most frequently, they are described as tense, high-strung, anxious, and jumpy.

These patients are given to obsessional thinking and to repeated ruminative preoccupation. Thinking is unoriginal and problem-solving is stereotyped rather than flexible. Although 63% finished high school, fewer of these patients than any other group have advanced education. Too, these patients are more forgetful than any other group. There frequently appears to be a fear in these patients of losing control; emotional "letting go" thus seems to be impossible for them. At the same time, self-assertion is just as difficult. The prognosis for patients with this profile is generally poor (60%) and the response to treatment in 85% of the cases studied is judged to be "no change" or "small improvement."

Rules

2 and 8 above 70 Ts

2 minus 8 less than 15 T-scores

7 greater than 4 and 6

8 greater than 1 and 3

8 minus 7 more than 5 T-scores

9 below 70 Ts

0 greater than 9

L and K less than F

Most Descriptive

68. Keeps people at a distance; avoids close interpersonal relationships (8.8) +

87. Is afraid of emotional involvement with others (8.6) +

7. Psychic conflicts are represented in somatic symptoms (8.2) +

- 20. Complains of difficulty in going to sleep (8.0) +
- 79. Is resentful (7.8) +
- 82. Gets appreciable "secondary gain" from symptoms (7.8) +
- 100. Obsessive thinking is present (7.8) +
- 12. Tends not to become involved in things; is passively resistant (7.6) +
- 44. Is distrustful of people in general; questions their motivations (7.6) +
- 56. Complains of weakness or easy fatigability (7.6)
- 93. Exhibits depression (manifest sad mood) (7.6)
- 99. Is stereotyped and unoriginal in approach to problems (7.6) + +
- 58. Tends to be ruminative and overideational (7.4)
- 78. Is irritable (7.4) +
- 85. Has inner conflicts about sexuality (7.8) +
- 105. Manifests hypochondriacal tendencies (7.4) +
- 32. Is tense, high-strung, and jumpy (7.2) +
- 54. Is defensive about admitting psychological conflicts (7.2) +
- 77. Is tearful and/or cries openly (7.2) +
- 9. Presents self as being physically, organically sick (7.0) +
- 48. Fears loss of control; cannot "let go" even when appropriate (7.0) + +
- 60. Has inner conflicts about self-assertion (7.0) +
- 71. Genotype has obsessive-compulsive features (7.0) +
- 75. Has inner conflict about emotional dependency (7.0)

Least Descriptive

- 108. Has the capacity for forming close interpersonal relationships (1.2) —
- 11. Is cheerful (1.4)
- 39. Genotype has psychopathic features (1.4) —
- 42. Is "normal," healthy, symptom free (1.4)
- 59. Is socially extroverted (outgoing) (1.4) —
- 36. Has a rapid personal tempo; thinks, talks, moves at a fast rate (1.6) —
- 50. Has a need to affiliate with others (1.6)
- 106. Has grandiose ideas (extreme is delusions of grandeur) (1.6) —
- 31. Has a high aspiration level for self; is ambitious; wants to get ahead (2.2)

- 41. Has good verbal-cognitive insight into own personality structure and dynamics (2.2)
- 107. Would be organized and adaptive when under stress or trauma (2.2)
- 35. Has a need to achieve; to strive to do something as well as possible (2.4)
- 3. Values wealth or material possessions and judges others in terms of them (2.6)
- 40. Genotype has schizoid features (2.6) —
- 49. Appears to be poised, self-assured, socially at ease (2.6)
- 61. Tends to be flippant both in word and gesture (2.6)
- 51. Exhibits good heterosexual adjustment (2.8)
- 63. Has a resilient ego-defense system; has a safe margin of integration (2.8)
- 104. Delusional thinking is present (2.8)
- 6. Places value on intellectual and cognitive activities, skills, and attitudes (3.0)
- 37. Defenses are fairly adequate in relieving psychological distress (3.0) +
- 67. Is able to sense other person's feelings; is an intuitive, empathic person (3.0)

28's

This pattern is quite infrequent in psychiatric groups and even rarer in normals. Hathaway and Meehl (1951b) found that depression, anxiety, and agitation predominated in the clinical picture that such patients present, although an important minority showed a variety of hysterical disorders. This relationship between hysteroid mechanisms and some forms of the schizophrenic process is an interesting and important one for careful research. Just as some hypochondriacal pictures are prodromal manifestations for a developing schizophrenic reaction, so hysterical symptoms or atypical spells may presage a more serious psychotic upset. The differentiation of serious upsets from the more benign and tractable hysterical disorders may be aided in part by evidence about the premorbid personality of the patient. For example, Hathaway and Meehl found that the patients with 28 codes were described as unsociable in contrast to the sociability of cases with 13 or 31 patterns, in whom a hysterical syndrome would be psychologically more consistent. As the illness reflected in this profile develops, the patients seem to suffer some form of psychological deficit, appearing as an inability to concentrate, a period of confusion, or a loss of efficiency in carrying out usual duties. These cases also develop sensitiveness or even suspiciousness and some show hypochondriacal behavior.

Diagnostically, persons with the 28 codes were most frequently labeled psychotic, generally psychotic depression (manic-depressive, depressed, or involuntional), although many were described as having some form of schizophrenia. Among the neurotic diagnoses, psychoneurosis, mixed, was more frequent than reactive depression, while a final diagnosis of either hypochondriasis or hysteria was rarely made. Guthrie also noted schizoid features in

the patients he studied with 28 codes, but seldom was a clear schizophrenic break reported. Confusion and apathetic indifference were the most frequent manifestations. The severity of the personality difficulties corresponded well with the elevations of profiles in this group. It should also be noted that Marks and Seeman include data on the 28 code type (see Chapter 3 for the defining characteristics of this pattern).

(Dahlstrom, Welsh, & Dahlstrom, 1979)

Description:

Childhood hurt and deprivation common, confusion, sense of being “broken”, concreteness, social awkwardness, dependency, tension, depression, blackouts, nausea, vomiting, seriously suicidal, sense of being rejected, inadequate

Possible Diagnoses:

Depression, Bipolar/Cyclothymic dis., Brain damage, PTSD, Generalized anxiety, Explosive, Panic, Schizoaffective dis.

Modifying Scales

- o Typically, Scale 2 and Scale 8 subscales are all elevated, reflecting the pervasive nature of this kind of depression.
- o Social Alienation (Pd4) and Self-Alienation (Pd5) are usually elevated, congruent with the deep sense of alienation characteristic of this profile.
- o When Scale 6 is coded third, frank paranoid symptomatology is usually present, including marked resentment, persecutory delusions, and delusions of control. Cognitive disorganization becomes more likely.
- o When the Poignancy Scale (Pa2) is elevated without the Ideas of External Influence Scale (Pa1) look for heightened sensitivity and a tendency to personalize above what is typical of the 2-8 code types.
- o It would not be surprising for Bizarre Mentation (BIZ) to be elevated given their almost delusional self-disdain. If BIZ, Psychoticization (PSYC), and or Aberrant Experience (RC8) are elevated above 70, then look for a possible psychotic depression.
- o Neurological Symptoms (HEA2) and Sensorimotor Dissociation (Sc6) are commonly elevated in this code, suggesting neurological or pseudoneurological sensory and motor symptoms.
- o Anxiety (ANX) will almost always be elevated even though Scale 7 may not be; but this reflects the diffuse and constant sense of anxiety associated with the 2-8 profile.

- o Examine the substance abuse scales MacAndrew Alcoholism Scale Revised (MAC-R), Addiction Acknowledgment Scale (AAS), and the Addiction Potential Scale (APS), for information about the role of substances in the symptom presentation.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Male

Low 0 Introverted or self-conscious or socially insecure (28), lacks skills with the opposite sex, lacks knowledge or information, aggressive or belligerent.

- Note: Scale coded low was infrequently associated with introversion or self-consciousness or social insecurity, lack of skills with the opposite sex.

Low 1 Introverted or self-conscious or socially insecure, lacks skills with the opposite sex.

Low 3/4/5/6/7 Lacks skills with the opposite sex.

Low 9 Introverted or self-conscious or socially insecure, lacks skills with the opposite sex.

Nothing Low Introverted or self-conscious or socially insecure, lacks skills with the opposite sex, indecisive, tense, unhappy, worries a great deal, insomnia, confused.

Female

Low 0 Anxieties, depressed, distractible in study, tense on examinations, verbal, lacks skills with the opposite sex.

- Note: Scale coded low was infrequently associated with depression and lack of skills with the opposite sex.

Low 1 Anxieties, depressed, distractible in study, lacks skills with the opposite sex, lacks self-confidence, physical inferiority.

Low 3 Anxieties, depressed, distractible in study, lacks skills with the opposite sex.

Low 4 Anxieties, depressed, distractible in study, lacks skills with the opposite sex, lacks self-confidence.

Low 5 Anxieties, depressed, nervous, distractible in study, tense on examinations, lacks skills with the opposite sex, socially shy, socially insecure, indecisive, wants answers.

Low 6 Anxieties, depressed, distractible in study, lacks skills with the opposite sex, socially insecure, lacks self-confidence, nonverbal.

Low 7 Anxieties, depressed, distractible in study, lacks skills with the opposite sex.

Low 9 Anxieties, depressed, distractible in study, lacks skills with the opposite sex, mother conflict.

Nothing Low Anxieties, depressed, distractible in study, lacks skills with the opposite sex, 8+ conferences, father conflict, mother conflict, sibling conflict.

(Drake & Oetting, 1959)

o **Check:** *ANX, FRS1, OBS, DEP, DEP1, DEP2, DEP3, DEP4, RC2, Hp, CogProb, DisOrg, HEA1, HEA2, HEA3, BIZ1, BIZ2, LSE1, LSE2, SOD1, WRK, AGGR (low), PSYC, Dr1, Dr2, Dr3, Dr4, Dr5, Hy3, Hy4, Pd4, Pd5, Pa1, Pa2, Sc1, Sc2, Sc3, Sc4, Sc5, Sc6, A, Es (low), MAC-R (low), MDS.*

TREATMENT

Typical histories involve repeated hurts by emotional abandonment and neglect in childhood. Many adults marry after a brief courtship. Early childhood histories suggest disruption, with mental illness, in the family of origin. Look for childhood histories where they experienced hostile neglect. Sexual problems are typical because of their fears of emotional closeness. A therapeutic relationship is hard to develop with the 28 individual because they feel broken, damaged, and unlovable, even by the therapist. They have a great deal of difficulty thinking clearly and therapy can be punctuated by long periods of silence. During these periods they are not actively processing or thinking coherently, but typically are shut down. Antidepressant medications are recommended, although these should be used in small doses, as the 28 individual is vulnerable to feeling easily knocked off balance. The 28 individual feels hopelessly defective, so reparenting, nurturing therapies are most effective. A number of initial sessions should be around rapport building, and the therapist should encourage trust by occasionally sharing his or her own vulnerabilities. 28 individuals often exhibit a long history of emotional hurt, and their adaptive response is to withdraw, shut down, and avoid emotional risks. Too much uncovering therapy is contraindicated because these individuals exhibit fragile self-esteem, which leads to them interpreting therapist insights as overwhelming criticism. Psychotherapy should be structured and concrete, using relaxation training, thought stopping, and cognitive behavioral techniques that allow the patient to maintain feelings of control, with rehearsal strategies to deal with their interpersonal anxiety. After trust is developed, insight therapy to help them develop a sense of empathy for themselves as emotionally wounded or hurt children can be effective, although the therapist should be careful to avoid the patient seeing these insights as confirming that they are hopelessly damaged due to their history. Some individuals with 28/82 codetype can manifest psychotic and even schizophrenic features. When appropriate, antipsychotic medications should be considered.

o **Treatment:** Rule out Schizophrenia; Schizoaffective Disorder. Biological treatments more effective than psychotherapy to improve symptomatic status and reduce suicide risk. Supportive and cognitive therapies can be effective in the post-acute phase, but defenses and apathy reduce motivation to engage in therapy.

- Possible diagnoses: major affective disorder (bipolar-depressed or major depression), schizophrenia or schizoaffective disorder, personality disorders (borderline, avoidant, obsessive-compulsive, schizoid; features likely to include liability, emotional instability, acting out). (Groth-Marnat, 2009)

Treatment Implications

These clients are likely to have multiple problems related to expressing their anger, relationship difficulties, and social withdrawal. In particular, they might lose control over their feelings of anger, which might be directed toward the therapist during times of stress. They are also likely to feel ambivalence toward relationships in general, and this may express itself in resistance to therapy. This ambivalence will also make it difficult to experiment with new strategies learned in therapy. Thus, therapy tends to be long term. The therapist potentially can provide a point of stability in an otherwise chaotic and unpredictable life. An important area that should be assessed both during the initial session(s) and throughout treatment is the potential for suicide. During times of crises, many persons with this profile might require medication to control their thoughts and feelings.

Therapy and Therapeutic Pitfalls

Mistrust is a central element of the profile, so opening up to the therapist is very difficult. The 2-8 clients have difficulty organizing their thoughts, and they lack a steady stream of experience to process within the therapy session. They tend to answer questions in a flat, concrete way, so little therapeutic “back and forth” can develop. Sessions can feel exhausting and even boring to the therapist. Eye contact is usually minimal, affect is flat, and thinking is stereotyped and lacking in richness. Helping the clients be more assertive, helping them organize their thinking, setting tangible goals, and reassuring them when they are thinking clearly can be helpful in building rapport, trust, and self-efficacy. Antidepressants are almost always needed, although beware of energizing antidepressants. Occasional and brief revisits to painful childhood experiences of emotional withdrawal by loved ones can be helpful in increasing their capacity for self-empathy and knowledge. The process of building basic trust and basic self-esteem tends to be prolonged. Sometimes, seeing clients three times a week for half an hour may be helpful in keeping them focused and avoiding therapist burnout. Assertiveness training, cognitive skill building, and self-esteem building exercises are all useful.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Treatment and Self-Help Suggestions

1. When you feel a dark or empty mood overcome you, see if you can identify whether you have been unfairly treated by someone or treated in a mean or critical way. Telling the person how you feel and what happened

to make you feel that way can help relieve your negative mood. Work with your therapist to learn how to speak up for yourself instead of holding it in. Your therapist can help you begin to be more assertive¹ by using techniques such as “I” statements to let a person know how you feel in a nonjudgmental way.

2. Talk therapy and medication can both be helpful for the sudden mood surges that you experience and the resulting confusion and anxiety. Medications can make psychotherapy more effective for some people, especially if you have trouble concentrating or find it difficult to rally the energy to talk about your problems. Discuss the possibility of medication with your therapist.²
3. See if you can become aware of negative, self-critical thoughts where you tell yourself that you are unlovable or somehow defective. This type of harsh self-judgment can cause a great deal of pain. Work with your therapist on ways to increase your self-esteem.³ There are a number of good techniques including personal wellness, setting goals, self-expression, looking at “core beliefs,” and monitoring your “self-talk.”
4. Although you may find it hard to muster the energy to socialize, the pattern of isolation and depression is a “downward spiral,” and one of the best ways to start to feel better is to reach out for social support and contact.⁴ Start with small steps: When you feel a bit stronger, you might consider contacting friends or family even if it is just by phone or for a brief get together. You may also consider joining a support group for depression. Many are offered at low to no cost and can be found by searching the Internet for depression support groups in your area.

¹ There is a distinct negative correlation between assertiveness and depression; studies have found that after learning to be more assertive subjects rate themselves as less depressed (Langone, 1979; Segal, 2005).

² The *Journal of the American Medical Association* (Fournier et al., 2010) estimated the relative benefits of medication versus placebo in a meta-analysis of studies from the past 30 years. The study found that the benefits of antidepressant medication over placebo increased with the severity of the depressive symptoms. The benefit of medication is substantial in severe depression and minimal to nonexistent in mild or moderate depression, but these are broad analyses and the cost–benefit of medication should be considered on an individual basis.

³ Though some studies find that positive affirmations are helpful (Philpot & Bamburg, 1996), others have found it to be neutral to harmful for those with very low self-esteem (Wood, Perunovic, & Lee, 2009). For situational low self-esteem, cognitive techniques and affirmations can help change maladaptive patterns, but for characterological low self-esteem the emphasis should be on negative core

beliefs, maladaptive schemas, and developing self-compassion (McKay & Fanning, 2000).

4 Studies have determined that not only is loneliness a by-product of depression, but it also contributes to the symptoms of depression. Learning skills to increase social support can help (Eisemann, 1984). (Levak, Siegel, Nichols, & Stolberg, 2011)

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you are a very thoughtful, analytical person who tends to withdraw when confronted with severe stress. Currently, you seem to have withdrawn into yourself and you're feeling less happy, positive, and optimistic than you would like to be. It is hard for you to enjoy much, and when others try to engage you or try to get you to do something positive, you feel apathetic and low energy. It appears that it is hard right now for you to get your thinking straight and you may experience feelings that your mind is foggy, so it is hard to remember and to make decisions. You may find yourself numb and feeling empty, even in moments when others would expect you to feel positive or even joyful. You may find yourself moving slowly and at times being inefficient and not getting things accomplished. You tend to be your own worst critic and currently you're feeling bad about yourself, feeling you're unlovable, and even worthless. It is hard to have hope and feel positive. Concentrating may be particularly difficult at this time. You may find yourself easily feeling guilty and thinking about past mistakes and what a bad person you are. You may have a number of physical symptoms of stress, and you might even feel that there is something really, basically, wrong with you. It is hard to open up to people, especially strangers, and it is hard for you let people get close to you because you're afraid of being hurt. No wonder you may at times feel irritable and easily angered. Sometimes people with your profile grew up in environments where a parent was cold or even coldly cruel. From an early age, you likely learned to withdraw as a way of protecting yourself. Currently, someone you felt close to may have withdrawn from you, possibly reawakening those feelings that you are damaged and unlovable, and that the future is hopeless. You may even think about dying because life feels no longer worthwhile. It is important that you discuss these feelings with your therapist. It may be hard for you to trust your therapist and, at times, you may feel lost for words in the therapy session. Find ways to switch off negative thoughts and work with your therapist on ways to assert yourself with others. Create a list of things that might make you feel better and force yourself to get one or two of those things done, even though you may lack the motivation to do so. Your therapist may also suggest some medicine so that you can sleep better, feel more rested, think more clearly, and have more energy.

Feedback Statements—Elevated Profiles (T-Score > 65)

Depression or Anhedonia

The profile suggests that you are experiencing a depression. It may frighten you to hear that you are depressed, but that does not mean that you are unusual or somehow incurable. It just means that you are experiencing a good deal of emotional pain right now. Much of the time, you are going through life as if you are sleepwalking, where the world feels somewhat unreal. Even when pleasurable moments occur, it's hard for you to feel excited or happy. This type of depression is called anhedonia.

Memory or Concentration Difficulties

The worst part about your depression is that it seems to affect your memory and your concentration. Much of the time, you feel like you're walking around in a fog; you probably lose or forget where you put things and forget about decisions you've made. You may find it hard to recognize people that you know well, and it's hard to concentrate for any length of time.

Sleep or Appetite Problems

You are either sleeping too much or too little because you can't get to sleep or, perhaps, because you wake up early and are unable to return to sleep. In other cases, you may sleep long hours but still wake up feeling groggy, tired, and lacking the sharpness and clarity that comes from a good night's sleep. You may also find that your appetite has been affected. Perhaps nothing tastes good, or perhaps you forget to eat. Alternatively, you may eat too much and gain weight or be unable to eat and lose weight.

Sexual Difficulties

You may have trouble trusting others, so you have little interest in sexual activity. You may have occasional thoughts about sex, but your thoughts might be disturbing and uncomfortable.

Anxiety

You may feel a sense of anxiety and dread; it may be hard for you to focus on any particular worry, but you feel a sense of fear in the pit of your stomach. Curiously, when things go wrong, you may feel indifferent, flat, and empty, even though you know you should do something about it.

Somatic Complaints

People with your kind of depression often experience physical symptoms. You might have headaches, feelings of weakness, tingling, twitching or numbness, or dizzy spells or times when you feel faint. You may have a hard time

keeping your balance or have problems with your vision or hearing or other vague and shifting physical complaints that can frighten you. Lightheadedness, dizziness, exhaustion, and preoccupations about what's wrong with you can further sap your energy.

Socially Withdrawn

Given how you are feeling, no wonder you want to withdraw from others and avoid people, even people you care about. You might dread seeing old friends or family members, and you might stay away from new social contacts. In new social situations, it may be hard for you to interact and engage people in any meaningful way.

Possible Thought Disorder

You may get caught up in small, even irrelevant, details of a problem. It may be difficult for you to determine whether you're thinking clearly or whether you're preoccupied in ways that are distorted. When you are tense, you may get so confused that you feel a sense of paranoia or even confusion about what is real.

Blunted or Inappropriate Affect

Because you are protecting yourself by not letting yourself get involved in life, sometimes your emotions may erupt in ways that puzzle or even frighten you. For example, you may find yourself laughing at a sad moment or crying when other people experience the situation as joyful. You may find yourself feeling angry or hostile at tender moments, and at other times you may feel a sense of empty deadness when you should be feeling some kind of an emotion. Those closest to you may find some of your emotional responses puzzling. You may talk about very painful things and show no emotion, even when you're talking about something that is quite upsetting to you or to others.

Feelings of Worthlessness

Almost all the time, you feel a deep sense of being broken, worthless, and unlovable. Even when people say positive things, it's hard for you to feel them. It's as if you protect yourself from disappointment by reminding yourself that you are worthless and that thinking positive thoughts about yourself is dangerous because you'll only be disappointed.

Derealization or Depersonalization

You may feel disconnected from the world, as if you are watching yourself in a movie. Sometimes it may feel as if things aren't real. This can be frightening to you, but it is common with this kind of depression.

Fears of Social Interaction

Sometimes you may become frightened about interacting with others. Perhaps it's because you're angry with them and don't want them to know, or perhaps you're afraid that they're going to be hateful or cruel to you. Or you may feel that interacting with others just takes too much work. Feeling a constant sense of dread and feeling broken, damaged, and defective, it's understandable that talking to other people frightens you in case they might see how you're feeling and use it against you.

Possible Suicidal Attempts

When life feels so draining, so empty, and so frightening, and you feel hopelessly damaged, it's no wonder you think about escaping from life. You might even think about dying, and you might actually want to attempt suicide. This would be important for you to discuss with your therapist.

Lifestyle and Background Feedback

People with your profile sometimes come from backgrounds where they felt neglected, emotionally deprived, and even treated cruelly. One of your parents may have experienced some depression or some other mental disorder, which left them unable to take care of you in any reasonable way. Perhaps it was someone else in your life who treated you coldly and made you feel unlovable, broken, and damaged. You may have learned at an early age to withdraw, to retreat into your own world, and to protect yourself from hurt by not caring, by not letting yourself get involved, and by pushing people away so they couldn't reject you. It may be that recently someone whom you saw as caring and supportive has started to withdraw from you and treat you with silence or even cruelty, and this has precipitated the depression. It's also possible that you've been through an accident or some other event that has left you feeling broken or damaged.

Normal-Range Feedback (T-score 50 to 65)

Your profile is within the normal range and reveals that you are a sensitive, creative, and responsible individual. Right now you may be feeling somewhat down and sad about some current predicament that you may be blaming yourself for. You may have periods of sadness and dissatisfaction where you feel that there is something "not quite right." You are a sensitive person, and, when stressed, you tend to withdraw from others, especially if you feel they are in any way hostile. Being assertive is difficult for you because you dislike conflict, and when you feel angry toward someone you will not likely express it. Under stress it may be difficult for you to make decisions, and during

these times you may have difficulty with your memory or concentration and your energy level. Though these mild symptoms are uncomfortable, the profile suggests that you can be readily helped with therapy and, in some cases, a temporary period of medication.

(Levak, Siegel, Nichols, & Stolberg, 2011)

281/821 Codes

In addition to the symptoms and traits associated with the 28/82 codetype, the 281 individual is likely to complain of numerous somatic complaints that may predominate over depression complaints. Usually, these somatic complaints are rather vague and medically atypical, as one would expect with the elevation on Scale 8. Tremors, temporary losses of vision, vague numbness, paresthesia, and even somatic delusions can be present. These delusions may reflect a psychotic depression since the physical symptoms are atypical, if not implausible, but the person may not show any other obvious psychotic disturbance. These somatic preoccupations may be an attempt to defend against a more florid outbreak of psychosis. If Scale 3 is also elevated, then the hysterical defenses associated with that scale mask the depth of the depression. The 1283 individual can exhibit 13 characteristics, with periods of smiling and crying, attempts to engage others into caretaking behavior, but also odd preoccupations and approach-avoidance conflicts in relationships.

TREATMENT

(SEE 12 /21AND 28/82 TREATMENT SECTIONS)

Although the addition of Scale 1 may decrease the possibility of suicide, this effect is not robust enough to ignore the suicide items on the MMPI-2. As in all depression profiles, the potential for suicide is a risk to consider. The 281 individual may complain of side effects of any medications administered, so they should be given in small doses until the patient feels a sense of control. Antidepressant/antipsychotic medications may diminish the somatic delusions. Treatment should be similar to the 28 individual, but could also use Gestalt techniques to explore what unconscious conflicts are being expressed through the somatic symptoms.

THERAPEUTIC FEEDBACK LANGUAGE

See feedback for the 28/82 codetype. Your profile also suggests that you are experiencing a number of physical symptoms that may be quite concerning to you. These symptoms may come and go, increasing when you are stressed. At times, you may be preoccupied with physical symptoms of decline, wondering whether you are physically suffering from some severe and debilitating disease. You may find yourself thinking about disease,

death, and decline, and even researching your symptoms, feeling a sense of panic about their implications. Some of these symptoms may be related to your current depression.

2813 Code

1. People with this profile tend to have somatic complaints, chronic tension, and dramatic tremors. They also may have intellectual confusion (Caldwell, 1972).
2. They may attempt to promote rescue by their therapists but will back off when the therapists try to help them. This type of person often sets the therapist up with the result that the therapist gets angry at him/her (Caldwell, 1972).
3. If these people are older than 40, they may complain of having thinking and recall problems. They may show organic deficits in testing, but they are not really as bad as the tests indicate. Their slowness causes the low scores on these tests (Caldwell, 1972).

284/824 Codes

In addition to the 28/82 symptoms and complaints, the elevation of Scale 4 adds feelings of distrust, alienation, and a tendency to act out under stress. Individuals with these elevations act out in ways that can appear senseless and self-defeating. Sometimes the anger is turned against themselves and sometimes against others. Suicidal and self-destructive behavior is typical, and often these individuals self-medicate to deal with their anhedonia and sense of emotional disconnectedness from others. They tend to be quite impulsive, and sometimes act aggressively, towards others or themselves—especially if they feel humiliated or rejected.

The elevation on Scale 2 can act as a suppressor of antisocial acting out predicted by the Scale 4 elevation. However, when acting out does occur, it is often impulsive, poorly thought through, and sometimes bizarrely sexual, and even incomprehensible. Because these individuals are afraid of emotional involvement with others, they experience internal conflicts about sexuality and may combine and confuse sexuality and aggression. Social and marital maladjustment is typical. In some adults, this code is associated with schizoid or schizophrenic conditions, and in these cases the *F* scale is usually elevated. (If Scale 4 is within five *T*-score points of Scale 2 or 8, see the interpretation of the 482/842 codetype.) Though paranoia may be present, it is less of a fixed, rational kind and more of a diffuse sense that the world is crumbling and that people cannot be trusted. In adolescents, this code may not represent the enduring pathology indicated for adults. Instead, this code may reflect the sullen rebelliousness and alienation from social groups that is found in some adolescents, and may reflect a more situational depression.

Nevertheless, poor impulse control, self-destructive and self-defeating behavior, and mental inefficiency would be present. Even if the *MAC-R* scale is not elevated above a raw score of 26, individuals with this codetype often self-medicate.

TREATMENT

In some cases, the 284/824 codetype reflects an individual who manifests a 48/84 codetype personality, but has recently become involved in a legal difficulty or difficulties with authority figures because of acting out. Their depression score is elevated because they feel trapped and bitter about their current situation. Once the situation has been resolved, these individuals continue to manifest more 48 characteristics without the depression. In other cases, this represents a stable personality pattern with chronic interpersonal difficulties, self-defeating, self-destructive behavior, profound alienation, and distrust of others. A history of rebellious, senseless, acting-out behavior would suggest a 48/84 profile with Scale 2 recently elevated if the individual is suffering from the consequences of their behavior. Antidepressant/antipsychotic medications would be less effective if the depression reflects a transitory disturbance due to acting-out behavior.

In either case, trust is a central issue for people with this codetype. The codetype reflects an individual who has experienced multiple blows to their sense of identity. Consequently, they are described as angry, alienated individuals who are cynical and lack empathy. Although these individuals are cautious about emotional ties, they also have an exaggerated need for affection. Some are diagnosed as psychotic with paranoid features, yet many do not evidence a gross or florid thought disorder. Look for childhood histories of caregiver rejection and even cruelty. In the Marks et al. (1974) sample, none reported affectionate parents. A large proportion of their sample was illegitimate and many experienced behavior problems throughout their school careers. Conceptually, this codetype reflects the “unwanted, unloved child,” with resulting craving for affection, yet a lack of trust when it is given. Consequently, they alternate between feelings of numb emptiness and episodic anger and demandingness. Reparenting, supportive therapies are usually required. These individuals have difficulty trusting the therapist and they put the therapist through “trust tests.” Working on the transference is an important component of therapy. When the patient starts to cancel sessions, it is usually an indication that the intensity of the therapy is overwhelming or

they are feeling the therapist “doesn’t care” about them. The 284 thinks people “wear masks” and are untrustworthy, perhaps a projection of their own manipulateness and role-playing. Behavioral techniques to help them control impulsive, self-defeating, and self-destructive behavior can be effective. Mindfulness therapy and dialectical behavior therapy can be helpful to relearn how to allow themselves to experience emotions and to label and express those emotions to others without being destructive. Rehearse ways to find emotional rewards rather than turning toward

chemical agents. Though these individuals act out sexually, they tend to report little emotional satisfaction from sexuality.

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you are currently somewhat trapped, down, and unhappy, so that little in life gives you pleasure. You may feel a sense of hopelessness and you may even think about dying as way of escaping. There are periods where you feel so alone and angry that you may act in self-defeating and self-destructive ways. At other times you may feel angry with others and the world in general, and you may give up and do things that get you into trouble. Sometimes people with your profile grow up with parents who were rejecting, cold, and even cruel. From an early age you learned to withdraw and to protect yourself by keeping up an emotional wall. You may now anticipate that people close to you are going to reject you and treat you cruelly. You may be demanding of others, wanting them to prove that they are trustworthy because you have been so badly hurt in the past. However, even if they do give you reason to trust them, it is hard for you to do so. At times you may feel a sense of anxiety, as if the world is a very unsafe place. At these times it may be especially hard to trust others, and you may feel that people are wearing “masks,” so it is hard for you to read them and know what they are truly thinking and feeling. Your therapist may want to give you some medication to help you sleep better and feel less anxious and more rested. Medicine may help you have a clearer mind so that you can remember, concentrate, and problem solve more efficiently. Be careful not to use non-prescribed chemical agents as a way to feel better. Sometimes your sense of emptiness can be so strong that you turn to drugs and/or alcohol or perhaps sexual behavior or some other self-destructive behavior in order to feel alive. Rehearse with your therapist how you can manage stress better, anticipating the kinds of things that knock you off balance, so you do not act out in self-defeating ways. Mindfulness therapy will help you recognize and label your emotions. Learning to trust others will also be helpful.

287/827 Codes

The interpretation is similar to the 278/728 codetype, although there are some differences. The coding of Scale 8 first or second, rather than third, predicts more identity damage, alienation, and confusion, and increases the likelihood of a depression, psychotic, or borderline diagnosis. Persons with this codetype manifest depression and anxiety, but also more severe thought disturbances, with tangential and circumstantial thinking, and even more sensitivity to criticism and general distrust of others. They almost always show significant cognitive impairments, reporting concentration difficulties, confusion, insomnia, and general inefficiency. Adjustment is marginal at best. Numerous physical symptoms are also likely manifested. Labile and inappropriate emotions and even hallucinations or a thought disorder may be present. These individuals are very cautious about becoming emotionally involved with

others and fear abandonment, so they maintain emotional distance. They are intensely moody and others find their moods hard to predict. Sexuality is almost always disturbed.

Suicidal thoughts, preoccupations, and verbalizations are likely. If the *K* scale is below a *T*-score of 50, and if Scales 9 and 4 are also elevated, the likelihood of self-destructive impulsiveness increases. Suicides that do occur are often poorly thought through and sometimes expressed in unusual or even bizarre ways.

- Kelley and King (1980) found the 2-8-7/8-2-7 profile group in a college client population had suicidal ideation. In addition, males had disruptive and tangential thought processes, inappropriate affect, and were disoriented, all suggestive of psychosis. However, they did not display overt psychotic symptoms. They were also depressed, had difficulty in concentration, and loss of interest. Females were seen as neurotic. They had difficulty concentrating and had made suicide attempts. They had no thought disorder but had derealization, la belle indifference, perfectionism, and alcohol abuse. Thus men and women with this profile were quite different.

TREATMENT

(SEE TREATMENT SECTION UNDER THE 278/728 CODETYPE FOR RECOMMENDATIONS)

The individual experiences a damaged identity and so has difficulty with the trust and emotional closeness needed for a therapeutic relationship. Look for childhood histories similar to the 278/728 individual, with emotional withdrawal, humiliation, rejection, teasing, and putdowns, as well as cruelty from primary caretakers. Some individuals exhibited eccentricities and were slow to mature as children. The individual likely suffers from an internalized negative self-image, so that any successes they experience are discounted.

Antidepressant/antipsychotic medications should be considered. Supportive reparenting therapies are suggested.

Self-esteem building, thought stopping, assertiveness training, mindfulness therapy, and CBT can all be useful.

Insight therapy should be avoided as it can be destabilizing to them.

THERAPEUTIC FEEDBACK LANGUAGE

Use the same feedback as 278 codetype. Currently, you may be experiencing periods of confusion and difficulties focusing and solving problems effectively. It may be hard for you to trust others and you may feel very alone and unable to let your guard down enough to discuss with your therapist how you are feeling. You may have had parents

who were cold or even cruel and rejecting. Currently you may be feeling the same sense of isolation and fearfulness that you experienced as a child. Discuss with your therapist if you are experiencing any loss of will to live and how you can develop techniques to switch off some of your anxiety.

289 Code

Male

Low 0 Introverted or self-conscious or socially insecure (28), lacks skills with the opposite sex, tense on examinations, lacks knowledge or information, lacks academic motivation, aggressive or belligerent, rationalizes a great deal.

- Note: Both Scale 9 coded high and Scale coded low were infrequently associated with lack of skills with the opposite sex. This pattern was infrequently associated with introversion or self-consciousness or social insecurity (9-0), shyness in the interview, being nonresponsive or nonverbal, being nonverbal or a nonrelator, indecisiveness.

Low 1/3/4/5/6/7 Introverted or self-conscious or socially insecure, lacks skills with the opposite sex, tense on examinations, aggressive or belligerent, rationalizes a great deal.

- Note: Scale 9 coded high was infrequently associated with lack of skills with the opposite sex.

Nothing Low Introverted or self-conscious or socially insecure, lacks skills with the opposite sex, tense, tense on examinations, indecisive, unhappy, worries a great deal, insomnia, confused, aggressive or belligerent, rationalizes a great deal.

- Note: Scale 9 coded high was infrequently associated with lack of skills with the opposite sex, indecisiveness, worrying a great deal.

Female

Low 0 Depressed, anxieties, restless, lacks self-confidence, confused, socially insecure (29), lacks skills with the opposite sex, socially extroverted (9-0), verbal, resistant in the interview, 8+ conferences, distractible in study, marriage oriented, tense on examinations.

- Note: Scale coded low was infrequently associated with depression, lack of self-confidence, confusion, social insecurity, lack of skills with the opposite sex.

Low 1 Depressed, anxieties, restless, lacks self-confidence, confused, physical inferiority, socially insecure (29), lacks skills with the opposite sex, socially extroverted (9-1), verbal, resistant in the interview, 8+ conferences, distractible in study.

Low 3 Depressed, anxieties, restless, lacks self-confidence, confused, socially insecure, lacks skills with the opposite sex, verbal, resistant in the interview, 8+ conferences, distractible in study, vague goals.

Low 4 Depressed, anxieties, restless, lacks self-confidence, confused, socially insecure, lacks skills with the opposite sex, shy in the interview, verbal, resistant in the interview, 8+ conferences, nonresponsive in the interview, distractible in study.

Low 5 Depressed, anxieties, restless, nervous, exhaustion, lacks self-confidence, confused, indecisive, socially insecure, socially shy, lacks skills with the opposite sex, verbal, resistant in the interview, 8+ conferences, wants answers, distractible in study, tense on examinations.

- Note: Scale 5 coded low was infrequently associated with resistance in the interview.

Low 6 Depressed, anxieties, restless, lacks self-confidence, confused, socially insecure, lacks skills with the opposite sex, verbal (89), resistant in the interview, 8+ conferences, nonverbal (2-6), distractible in study.

Low 7 Depressed, anxieties, restless, lacks self-confidence, confused, socially insecure, lacks skills with the opposite sex, verbal, resistant in the interview, 8+ conferences, distractible in study.

Nothing Low Depressed, anxieties, restless, lacks self-confidence, confused, socially insecure, lacks skills with the opposite sex, verbal, resistant in the interview, 8 + conferences, distractible in study, father conflict, mother conflict, sibling conflict.

(Drake & Oetting, 1959)

29/92 Codes

Code-Type 2-9/9-2

Descriptors

Complaints

Moody, restless, irritable, temper outbursts, driven, anxious, somatic complaints, sleep difficulties, eating problems, alcohol or chemical abuse

Thoughts

Worried, catastrophizing, grandiose, distractible, cynical or suspicious, stimulus-seeking

Emotions

Turbulent or unstable, irritable, pressured, euphoric, depressed

Traits and Behaviors

Impulsive, high-strung, explosive, ambitious, fears of failure, overactive, impatient, substance abuse, may have a brain injury, mood disorder

(Levak, Siegel, Nichols, & Stolberg, 2011)

Therapist's Notes

The 2-9 code type is a contradiction. Elevations on Scale 9 are consistent with someone who is surgent, assertive, optimistic, euphoric, confident, dramatic, and driven. However, elevations on Scale 2 suggest depression, low energy, a slowed pace, feelings of hopelessness, and low self-esteem. A 2-9 profile is analogous to driving a car at high speed with the brakes on. The 2-9 individuals are buffeted by constant competing impulses, defenses, and emotional states. In some cases, the oscillation between these two states is a manifestation of a true bipolar disorder. This bipolar disorder would involve surges of hypomanic or manic activity with overcommitment, irritability, euphoria, hostility, and impulsive behavior followed by periods of despondency, depression, guilt, and anxiety about the effects associated with impulsive manic overactivity. In other cases, however, the combination of these two scales reflects an internal tension, agitation, and irritability without clear manifestations of depression or of euphoria and mania. These individuals experience a high level of internal emotional pressure and nervousness. In the presence of a

history of instability, moodiness, tension, and high-strung behavior, the profile may reflect a stable personality pattern. Without such a history, rule out organicity or trauma due to a recent injury as well as hypomanic individuals slipping into depression or depressives emerging into a hypomanic episode. If the 2-9 elevation is significant, it may reflect a bipolar disorder with psychotic features. This is especially true if Scale 8 is also elevated. In some cases, the 2-9 profiles reflect an agitated depression without mania, although in other cases they may reflect an intermediate phase of a bipolar disorder. These individuals may go from being excited, positive, and engaging to being upset, angry, and catastrophizing quickly, possibly within minutes, often precipitated by external situations. Others may find this moody, unstable behavior puzzling because the shifts are sudden and triggered by apparently minor events. Jovial, even buoyant individuals may suddenly become angry, irritable, and explosive over a late arrival, the loss of car keys, or some other minor event. Once the situation is resolved, an explosive episode may be quickly followed by congeniality. Temper outbursts are a problem for 2-9 individuals, who live in a constant state of tension. They anticipate that a minor frustration or setback will lead to severe loss of possessions, status, or control. Minor events thus become potentially catastrophic, leading to overreactivity, anger, and overprotection. Living with the 2-9 individuals is highly taxing for others because they are rarely in equilibrium. Rather, they are driven to success, achievement, excitement, stimulation, and approval and overreact to loss and frustration with anger. They tend to have an argumentative style, as if all interactions could potentially lead to a loss of control or status. They can be quite talkative and extroverted, especially if Scale 0 is low. Individuals with the 2-9 code type are associated with addiction proneness. They may use alcohol in an attempt to medicate their intense internal pressure and agitation. Alcohol may also aggravate their irritability, explosiveness, and the severity of their mood swings. In some cases, blackouts reflect the tendency of individuals with elevations on Scale 9 to have a greater chance of abusing alcohol and other drugs. Beware of aggressiveness under the influence of alcohol. Sleep, eating, and concentration may be adversely affected, as one would expect with both depression and hypomania. These individuals are very sensitive to any kind of loss or narcissistic injury. They tend to be suspicious, not in a paranoid way but, rather, in a competitive and driven way, as if life is always a zero-sum game of winners and losers. Scanning the environment for the possibility of loss, they can appear negative, cynical, suspicious, and argumentative. Hyperactivity, controlling, and interrupting serve to keep the focus away from any possibility of loss of stature and self-esteem. The 2-9 is unable to be in the moment. Thoughts of future desires or reminders of past frustrations interrupt moments of pleasure or satisfaction. Although the 2-9 individuals crave approval and recognition, when they get it they resist enjoying it, reflecting their fear that it is transitory. It's as if they are fighting a steady battle on two fronts. Grabbing at every opportunity to maximize their status and rewards, they are also running away from feeling any sense of loss or frustration.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Lifestyle and Family Background

The 2-9 code types are extremely preoccupied with success and avoiding failure. Essentially, the profile reflects an internal battle to avoid experiencing depression and to “get ahead” to achieve success and self-esteem. Look for a childhood history of high achievement expectations with frequent frustrations and setbacks. Perhaps as children they felt that the odds against success were overwhelming, or perhaps they actually experienced a number of setbacks and losses. In other cases they felt pressure to achieve and succeed, but without the means to do so. These individuals may have been diagnosed with attention deficit hyperactivity disorder (ADHD) with subsequent erratic achievement. The conditioning experience tends to be one of success based on effort but with constant apprehensions about failure. By keeping control, maintaining attention, and grabbing at opportunities, these clients are always striving to get ahead and to preempt loss by building achievement “reserves.” Any recent setbacks or losses to self-esteem could be the precipitating event for this disturbance.

(Levak, Siegel, Nichols, & Stolberg, 2011)

This is a rare profile and it most often occurs with individuals diagnosed with bipolar disorder. The 29/92 individual may appear anxious or agitated, and can be mistakenly diagnosed as suffering from an anxiety disorder. However, this codetype suggests mood swings, irritability, and agitation, rather than anxiety. Scale 2 cancels out the euphoria of Scale 9, and Scale 9 modifies the depressive features and sadness associated with Scale 2. The 29 individual is tense, moody, irritable and, at times, grandiose, overly optimistic, and cheerful. In some cases, this profile reflects an individual whose bipolarity is shifting from either depression or mania into its opposite. A clinical history should determine whether the individual has episodes of mania and depression, or whether their codetype reflects a stable, high-strung personality type. During periods where Scale 9 appears to be dominant, they are excitable, positive, and euphoric, but can quickly become angry, upset, and despondent, triggered by small external events. Sometimes the moods can swing rapidly within a short period of time. Others view them as moody, irritable, unstable, and hard to predict. Often they exhibit temper outbursts, and people feel on edge around them. They appear inconsistent, “selling” one idea at a particular moment and then denigrating the same idea in the next. When hypomania is present, it is pressured and forced, while depression is manifested as tense and energized pessimism rather than flat and hopeless. These individuals can be impulsive and overreact to frustration. Most often, Scale 4 or 3 is the third highest elevation.

Three sub-types of 29/92 may obtain this codetype:

1. An individual with an agitated depression marked by overtly depressed behaviors, such as weeping, catastrophizing, depressive rumination, and an obsession with protecting against loss. Look for childhood histories with parents who put a great deal of emphasis on achievement and success.
2. An individual who is attempting to cope with underlying depression, using manic defenses. Grandiose thinking and overcommitment may temporarily mask the underlying depressive symptomatology.
3. This codetype has been associated with organic brain injury/disease. The 29/92 individuals may be aware of their reduced abilities and are attempting to deal with this by overactivity. In the presence of any recent head trauma, neurological and neuropsychological testing is recommended.

o **Definition:** A rare and unstable profile. It is found most commonly in patients with Bipolar Disorder who are in transition from a manic to a depressed state (manic defense) or vice versa. May be seen as so-called agitated depression.

- o Emotional turbulence and instability with anxiety, tension, moodiness, agitation, restlessness, irritability, and disturbed sleep. Driven. Veers between excitability and upset or despondency. Distress tends to be generalized rather than differentiated into depression, anxiety, apprehensiveness, and so forth. Overactivity, when present, is pressured and forced rather than natural and euphoric. Depression, when present, is manifested in anhedonia, vegetative signs, and pessimism and other depressive attitudes, rather than in sadness or (stable) dysphoria. Seeks stimulation as a distraction from subjective distress. Strong concerns and worries over declining health (feels stressed and sick) and inability to work. High-strung and irritable, impulsive, overreactive to frustration and narcissistic injury, and quick to experience and express anger and hostility, sometimes explosively. Cynical and suspicious. Ego-dystonic dependency. Prone to passive-aggressive struggles. Extroverted but exaggerates self-confidence. Look for history of mood disorder, substance abuse, or both.
- o Self---centered, narcissistic; ruminates about self---worth; expresses concern about achieving at high level but sets self-up for failure; in younger persons may suggest identity crisis o Anxious, tense; somatic complaints in gastrointestinal tract; not particularly depressed but may have history of serious depression; uses alcohol as escape from stress and pressure; denying feelings of inadequacy and worthlessness and defending against depression through excessive activity; alternating periods of increased activity and fatigue; most common diagnosis is manic--- depressive psychosis; sometimes found for brain---damaged patients who have lost control or who are trying to cope with deficits through excessive activity

- o Uses alcohol as escape from stress and pressure; denying feelings of inadequacy and worthlessness and defending against depression through excessive activity; alternating periods of increased activity and fatigue; most common diagnosis is manic---depressive psychosis; sometime found for brain---damaged patients who have lost control or who are trying to cope with deficits through excessive activity

This high point pair often reflects an agitated depression in which tension is discharged through heightened motor activity. Individuals with this high point pair are overly expressive affectively, are extremely narcissistic, and ruminate expressively regarding their self-worth. Although they may express concern about achieving at a high level, it often appears that they set themselves up for failure. Another interpretation is that these clients are denying underlying feelings of inadequacy and worthlessness and may be attempting to use a variety of manic mechanisms such as hyperactivity, denial of poor morale, and overinvolvement with others—to avoid focusing on their depression. In other words, individuals with this high point pair are experiencing a hypomanic process that is no longer sufficient to obscure their depressive features, at least not on the MMPI-2. Both types of clients will appear tense and restless and will show irritability and ready anger at minor obstacles and frustrations. In younger clients, this high point pair may be suggestive of an identity crisis characterized by a lack of personal and vocational direction as well as numerous existential concerns. In older clients, this high point pair may be a reaction to physical disability or reflect a melancholic depression.

Symptoms and Behaviors

Although anxiety and depression are present with the 29/92 code, a high level of energy also predominates. This energy may be associated with a loss of control, or it may also serve to defend against experiencing underlying depressive feelings. By speeding up their level of activity, these individuals can distract themselves from unpleasant depressive experiences. At times, this will be successful, but they may also use alcohol either to relax or to decrease their depression. With moderate elevations, this code will, at the very least, reflect tension and restlessness. Often, these persons will ruminate on feelings of worthlessness. They are typically perceived as self-absorbed and self-centered. Somatic complaints (especially upper-gastrointestinal) and sporadic alcohol abuse are common. They have high needs for achievement but may paradoxically set themselves up for failure. When this code type occurs among younger persons, it might reflect a vocational crisis with a resulting loss of identity. Sometimes brain-injured persons have this profile, which reflects their feeling of loss of control over their thoughts and feelings, but they attempt to compensate by speeding up their level of activity.

If both scales are in the higher elevations, a mixed bipolar depression is suggested. However, both scales can change according to the particular phase the patient is in. This code can also reflect certain types of brain-injured patients or a cyclothymic disorder.

Personality and Interpersonal Characteristics

The core feelings will be a sense of inadequacy and worthlessness. However, the person may deny these feelings and defend against them with excessive activity.

29/92 persons tend to be self-centered and narcissistic, and they ruminate excessively about self-worth. Although they may express concern about achieving at a high level, it often appears that they set themselves up for failure. In younger persons, the 29/92 code type may be suggestive of an identity crisis characterized by lack of personal and vocational direction. 29/92 persons report feeling tense and anxious, and somatic complaints, often centering in the upper gastrointestinal tract, are common. Although they may not appear to be clinically depressed at the time they are examined, their histories typically suggest periods of serious depression. Excessive use of alcohol may be employed as an escape from stress and pressure. The 29/92 code type is found primarily among individuals who are denying underlying feelings of inadequacy and worthlessness and defending against depression through excessive activity. Alternating periods of increased activity and fatigue may occur. Although the most common diagnosis for psychiatric patients with the 29/92 code type is bipolar disorder, it sometimes is found for patients with brain damage who have lost emotional control or who are trying to cope with deficits through excessive activity

In spite of the apparent psychological contradiction in this high-point pairing, the 29 pattern appears with sufficient frequency in both normals and psychiatric populations to cast doubt on the unidimensionality of this set of personality characteristics. Often the manic features are most prominent, serving to hide the depressive upset from outside observers and even from the subject himself. Guthrie noted that the medical patients showing this code type were not described as depressed. Rather they showed a picture of tension and anxiety, the tenseness at times related to upper gastrointestinal complaints or to fatigue. Alcoholic histories appeared for the men with this pattern. None of these patients was in serious difficulties and none visited the physician frequently. They responded quite well to the physical therapies used by the internist. Drake found aggressive or antagonistic behavior in college counselees with the 29 pattern.

(Dahlstrom, Welsh, & Dahlstrom, 1979)

- a. See also the 9-2 combination, p. 224.

- I. This is a rare profile but may be seen in older populations. It can indicate a brain lesion or deterioration (Lachar, 1974).
- II. This person tends to be agitated (Hovey & Lewis, 1967).
- III. He/she may show agitated depression with the depression sometimes masked by activity. The person with the 2-9 combination is different from the person with the 2-7 combination in that less obsessive thinking and rigidity is seen, and more motor activity is evident.
- IV. Alternating periods of activity and fatigue may occur (Graham, 1977).
- V. A feeling of pressure for the client without euphoria and grandiosity may be observed in people with high 2 and 9 scale scores. This pressure usually alternates with fatigue. The prognosis is good for these people (Caldwell, 1972).
- VI. Graham (1977) has hypothesized that this code may be found primarily for people who have feelings of inadequacy and worthlessness but are trying to deny them.
- VII. This person, when a child, may have had to be emotional to get attention (Caldwell, 1974).
- VIII. Heavy drinking may be present for men with this pattern.
- IX. Aggressive and antagonistic behavior is found in college counselees with this pattern. They also tend to rationalize a great deal (Drake & Oetting, 1959).
- X. Test anxiety is seen in college students with this pattern (Oetting, 1966).

Description:

Manic defenses against depression, self-centered, agitated, moody, irritable, anxious, somatic problems, narcissistic, exhibitionistic, competitive

Possible Diagnoses:

Bipolar, Brain damage, Alcoholism

Modifying Scales

- o When Scale 1 is elevated third, there is an aggravation of somatic symptoms and preoccupations and complaints about them. Fears of decline and loss of control and power would be aggravated by a focus on somatic decline.

- o When Scale 7 is elevated third, they would be even more anxious, tense, and obsessive. Phobias, compulsions, and extreme anxiety around failure would be typical. Scale 2 elevations are associated with a sense of responsibility and guilt; Scale 9 is associated with needs for performance and achievement; and the elevation of Scale 7 would add guilt and anxiety about failure to the overall picture.
- o When Scale 8 is elevated third, look for the possibility of psychotic thought processes. This would be especially true if Bizarre Mentation (BIZ), or Psychoticism (PSYC) and/or Aberrant Experience (RC8) are also elevated. The 2-9-8 code type could reflect a psychotic agitated depression or schizo-manic episode. The 2-9 individuals have sexual performance problems, as one would expect with individuals who are very fearful of loss of esteem and status, but if Scale 8 is elevated, this would add fears of being defective and damaged. When Anger (ANG), especially Explosive Behavior (ANG1), is also elevated, the explosive episodes would be magnified and potentially dangerous.
- o Elevations on Misanthropic Beliefs (CYN1) and Interpersonal Suspiciousness (CYN2) would aggravate the distrust and cynicism
- o When Antisocial Practices (ASP) and or Antisocial Behavior (RC4) are elevated, the impulsive, hypomanic behavior associated with the profile could lead to occasional antisocial behavior.
- o Typically, Type A Behavior (TPA) is also elevated, reflecting the irritability and impatience associated with the code type. Elevations on any subscales associated with irritability, anger, and even hostility would aggravate the natural traits associated with this code type.
- o When K is elevated, clients can overcontrol both the mania and the depression, leading to more precipitous mood swings.
- o Examine the substance abuse scales MacAndrew Alcoholism Scale Revised (MAC-R), Addiction Acknowledgment Scale (AAS), and Addiction Potential Sale (APS) for information about the role of substances in the symptom presentation.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Male

Low 0 Tense on examinations, aggressive or belligerent, rationalizes a great deal. This pattern was infrequently associated with introversion or self consciousness or social insecurity, shyness in the interview, being nonresponsive or nonverbal, being nonverbal or a nonrelator, indecisiveness.

Low 1/3/4/5/6/7/8 Tense on examinations, aggressive or belligerent, rationalizes a great deal.

Nothing Low Introverted or self-conscious or socially insecure, lacks skills with the opposite sex, tense, tense on examinations, unhappy, worries a great deal, insomnia, aggressive or belligerent, rationalizes a great deal.

- Note: Scale 9 coded high was infrequently associated with worrying a great deal and lack of skills with the opposite sex.

Female

Low 0 Lacks self-confidence, socially insecure (29) , socially extroverted (9-0) verbal, marriage oriented, tense on examinations.

- Note: Scale coded low was infrequently associated with lack of self-confidence and social insecurity.

Low 1 Lacks self-confidence, physical inferiority, socially insecure (29), socially extroverted (9-1), vague goals.

Low 3 Lacks self-confidence, socially insecure, vague goals.

Low 4 Lacks self-confidence, socially insecure, shy in the interview, nonresponsive in the interview.

Low 5 Lacks self-confidence, indecisive, socially insecure, socially shy, lacks skills with the opposite sex, verbal, wants answers, tense on examinations, depressed, nervous, anxieties, exhaustion.

Low 6 Lacks self-confidence, socially insecure, nonverbal.

Low 7/8 Lacks self-confidence, socially insecure.

Nothing Low Lacks self-confidence, socially insecure, lacks skills with the opposite sex, depressed.

(Drake & Oetting, 1959)

o **Check:** *ANX, DEP, DEP1, DEP2, DEP3, DEP4, RC2, HEA3, ANG1, ANG2, CYN1, CYN2, ASP1, TPA2, SOD2*

(low), *Dr1, Dr2, Dr3, Dr4, Dr5, Hy3, Pa1, Pa3* (low), *Sc3, Sc4, Ma1, Ma2, Ma3, Ma4, MAC-R*.

TREATMENT

The 29/92 individual is particularly susceptible to self-medication with alcohol. It is important to rule out bipolar disorder or a major depressive episode with agitation. The 29 individual is vulnerable to impulsive suicidal behavior, so monitor the antidepressant medications carefully, as with other depression codetypes. If Scale 4 is elevated, there is likely to be impulsiveness and increased self-defeating behavior. When a 294 individual begins to feel better, they may act out in more reckless ways. If Scale 7 is coded third, there is a great deal of fear of failure, and a tendency to develop compulsive, repetitive behaviors as a defense against anxiety. If Scale 8 is coded third, then the individual

manifests an identity panic, with fears of being rejected and deemed as broken and damaged by others. Some of the hypomanic activity may be a defense against a panic resulting from a recent rejection. Even if the *MAC-R* scale is not elevated, this codetype is associated with chemical addiction and self-medication. Some individuals with this codetype experience blackouts and mood swings while under the influence of chemical agents. Aggressive behavior is likely when intoxicated.

Explore whether the individual has experienced setbacks that led to perceived rejection by loved ones. Helping the individual set realistic goals and using CBT to enable them recognize what kind of events can trigger mood swings can be useful. Helping them learn to anticipate stress and cognitively control their mood shifts, along with relaxation training, self-esteem building, and physical exercise as a way of “burning” off excess energy can also be useful.

o **Treatment:** Rule out Bipolar Disorder, Mixed; Major Depressive Episode with agitation; Cyclothymia. Risk of impulsive suicide. Consider retesting after an interval of observation and change in mental status as a guide to treatment. Consider neuropsychological evaluation.

- Frequent diagnoses: mixed bipolar depression—both scales can change according to the particular phase the patient is in (state-dependent scales), cyclothymic disorder, brain injured. (Groth-Marnat, 2009)

Treatment Implications

Because alternating periods of intense activity followed by exhaustion and depression often occur, a major challenge of treatment is to stabilize these mood and activity swings. This might be further complicated by a long-standing history of alcohol or drug abuse. In addition, suicide potential should be carefully monitored. During initial assessment, depression may not be immediately apparent. However, a careful consideration of the client’s background will reveal long-term but sporadic phases of depression.

Therapy and Therapeutic Pitfalls

Anytime an agitated depression is encountered, the therapist should inquire about suicide risk factors. Suicidal thoughts associated with Scale 2 combined with the impulsivity of Scale 9 can be dangerous. Medication is complicated because, in some cases, the profile reflects an agitated depression, a hypomanic disorder, or a long-standing agitated personality style. Energizing antidepressants may precipitate mania, and sedating antidepressants may aggravate the depression; therefore, diligence is required. Mood stabilizers for impulsivity and irritability may be useful. Clients’ histories would clarify whether the profile reflects a stable, long-term personality pattern or a

recent, reactive disturbance or a neurological disorder. After identifying the causes of their profound fear of failure, psychotherapy should focus on helping them ascertain what they really want versus internalized parental expectations. Thought stopping, relaxation training, mindfulness training (Hofmann, Sawyer, Witt, & Oh, 2010), and CBT (Zaretsky, 2003) to help them learn emotional control can all be useful. Help them to identify when they are experiencing surges of intense emotion and teach them not to act on those transitory feelings. Help them to focus on specific loss situations, and teach them to recognize their emotions around those losses so that they can learn to experience sad moments without panic. Help them recognize that they are emotionally overreactive, both on the exuberant, positive end of the spectrum and on the negative, dysphoric end. Teach emotional management, and help them realize that they are driven by fear of loss to help them anticipate difficult situations and find corrective behavioral strategies to deal with anxiety and frustration. The 2-9 code types can be quite irritable, explosive, and confrontational with the therapist. Emotional eruptions are a part of their emotional landscape, so not taking these personally is a necessary therapist skill.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Treatment and Self-Help Suggestions

1. Your doctor may want to consider medication, which could help you feel better quickly. The type of medication or combination of medications you receive will depend on the severity of your symptoms and how long you have been experiencing such mood swings.¹
2. Research has shown that regular aerobic exercise can decrease stress and has a very positive effect on treating depression and mood swings. Yoga classes are also helpful in managing stress, anxiety, and depression.²
3. Although medication is an effective treatment, it will work best in combination with therapy that addresses some of your negative ways of thinking and your tendency to see even minor setbacks as catastrophic.³ Discuss with your therapist some of the typical types of distorted thinking that fuel mental health problems. For example, *overgeneralization* is making unwarranted broad negative conclusions; *fortune telling* is believing you can accurately predict the future; *catastrophizing* is expecting the worst to happen, no matter what; and *emotional reasoning* is the belief that if “I feel it, it must be true.”
4. Relaxation techniques such as mindfulness meditation may help you to better manage the ups and downs of your emotional responses.⁴ Mindfulness involves paying attention to the present moment in a nonjudgmental way to foster a quality of curiosity and openness. For more information on mindfulness exercises and techniques see www.mindfulnessstapes.com. Mindfulness classes, books, or tapes can teach

you about breathing techniques, patience, and ways to observe your immediate experience without analyzing, judging, or acting prematurely.

5. A journal to help you to recognize some of the expectations your parents may have placed on you as a child. Determine what your own wants are versus the expectations. You may have simply adopted them from your parents without really thinking them through.
6. Work with your therapist to identify some of the most distressing and negative intrusive thoughts that you have. Thought stopping is an effective technique you can practice to help you prevent the types of unwanted thoughts that can make you feel depressed or angry. Several forms of thought stopping are effective. One quick technique involves picturing or saying out loud, “Stop,” whenever you experience these types of unwanted thoughts. You then replace the thought with a pleasant image or affirmation that is more positive (e.g., “I have felt this way before, and I know I can handle this”).

¹ With bipolar disorder there are often strong biological factors so the primary course of action is medication although medication compliance is often an issue. Negative attitudes toward medication, difficulty with medication routines, and comorbid substance abuse can all contribute to problems with noncompliance (Sajatovic et al., 2009). Openly exploring noncompliance with a collaborative and problem-solving approach can help the client overcome negative attitudes toward medication.

² While the literature on physical exercise and depression has been somewhat confusing, with both positive and negative effects being reported, cross-sectional and longitudinal studies indicate that aerobic exercise has antidepressant and anxiolytic effects and can protect against the harmful consequences of stress (Salmon, 2001). Additionally, a review of articles investigating bipolar disorder and exercise reveals that exercise has a robust effect on both psychiatric and somatic health in bipolar disorder (Alsuwaidan, Kucyi, Law, & McIntyre, 2009). In a group of psychiatric inpatients, yoga was associated with improved mood (Lavey, Sherman, Mueser, Osborne, Currier, & Wolfe, 2005).

³ Medication is most often the foundation of treatment for bipolar disorder, but therapeutic interventions such as cognitive-behavioral therapy significantly lessen the number of future episodes, contribute to medication compliance, and reduce the duration of mood swings (Zaretsky, 2003).

⁴ Studies suggest that mindfulness-based training is a promising intervention for anxiety and depression (Hofmann et al., 2010), but few studies have examined mindfulness-based treatment for bipolar disorder. One pilot study (Miklowitz et al., 2009) showed promising results in the reduction of depression, suicidal ideation, and, to a lesser extent, manic and anxious symptoms for clients with bipolar disorder who participated in an 8-week mindfulness-based cognitive therapy (MBCT) class. (Levak, Siegel, Nichols, & Stolberg, 2011)

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you are a person who can have moments of high energy, optimism, positive thinking, and productivity. However, it also suggests that small setbacks or perceived frustrations can quickly lead to you becoming down, even depressed, negative, and angry. As an analogy, you are driving through life with one foot on the accelerator, but the other foot on the brake. It is as if you are going through life driven to succeed and achieve, to prove to yourself that you are worthy of being loved, and at the same time you're looking over your shoulder to see how things can go wrong and how you can fail. This internal pressure and these mixed feelings lead to you often feeling extremely tense. Small events can switch your mood from being up and positive to down and negative. You feel your world is somewhat unpredictable and fragile, and you're constantly on edge, trying to predict how to protect against loss. Others may see your mood swings as hard to predict and find your tendency to be high-strung as

difficult to deal with, perhaps even irritating. Some people with your profile use chemical agents as a way to try to regulate their mood. You may experience a constant sense of tension as you approach goals quickly, with lots of energy, and then get defeated and feel hopeless if something goes wrong. Perhaps growing up you felt a great need to achieve and succeed, but you often felt frustrated. You may have felt that no matter what you did it wouldn't be good enough, and you felt vulnerable to losing the love of people you cared about. No wonder you go through life now always a little tense, as if afraid of loss or setback, pushing yourself hard to achieve and succeed. In some cases, your profile suggests a mood instability that may respond well to a mood stabilizing medication. In other situations, people with your profile can learn to manage their mood swings. Work with your therapist to recognize the kinds of events that can trigger your mood swings, usually an event that frightens you, because you see it as potentially catastrophic. Learn to switch off your negative thoughts and recognize when surges of excitability lead you toward over-commitment or being too positive. Avoid chemical agents other than prescription medication. Exercise, mindfulness therapy, and CBT can help you switch off negative thoughts. Should you have had any recent accidents or trauma to the head, your mood swings may be precipitated by the recent physical trauma. It would be important to discuss this with a neurologist.

Normal-Range Feedback (T-score 50 to 65)

Your profile is within the normal range and indicates that you may be feeling somewhat tense, moody, and irritable right now. It's possible that you have experienced a recent loss or frustration that is aggravating shifts in your mood. It's also possible that you may have always been somewhat volatile. People with your profile are susceptible to mild mood swings in which they go from being upbeat and energetic to being pessimistic rather quickly. You may have

periods of high energy followed by procrastination and inefficiency. You may experience internal tension and anxiety, especially if you feel you are failing at something or are losing control over a situation or if somebody is in your way. You may use alcohol or drugs as a way to manage these surges of emotion, and chemical agents may make you more volatile and impulsive. You may have a quick temper, and when people get in your way you let them know it, even though it may get you into trouble. There are periods when even small setbacks loom large and thrust you into a period of gloom and disappointment. You feel best when working on new projects or become excited about some new idea.

Feedback Statements—Elevated Profiles (T-Score > 65)

Moody or Restless

Your profile shows that you are quite moody. You may be feeling upbeat, positive, and happy one minute and then, suddenly, some small setback or loss will make you angry, upset, pessimistic, and unhappy. Your mood swings may occur within a few hours or even a few minutes of each other. Your profile suggests that you are very restless. You may feel very distractible so that it's hard to ever relax and feel at peace. It's as if your whole body is wired, on edge, and ready for action.

Euphoric or Impulsive

You may experience moments where you are filled with bubbling energy and drive. Moments of euphoria may lead you to act impulsively, and you may overcommit to too many tasks and activities. You may also tell people off and feel so good that you feel invincible.

Depression

These euphoric periods may be followed by periods of depression, perhaps prompted by some external event or because you wore yourself out with energy and over-commitment. When you feel depressed, you may get quite despondent and bleak, forgetting how positive you felt not long ago.

Irritable or Temper Outbursts

Feeling wired and ready for action, you may find yourself easily irritated and angry. You hate to be kept waiting, and you get angry if people are in your way when you're ready to move into action. You might throw things, blow up, tell people off, or just quietly seethe with anger. It's as if you feel pressured from the inside and as if the world is moving too slowly and you can't get everything accomplished that you need to.

Driven

You are driven to achieve and succeed. Everything is a challenge for you, and you want to make the most of it. You may find yourself feeling tense and urgent, as if you are behind or on edge and should be somewhere else doing something else. This constant sense of being driven may make you quite successful but also vulnerable to sudden setbacks due to impulsivity. You may find that you are unsatisfied and unable to enjoy your successes.

Anxious or Worried

Feeling this sense of drive and impatience may often leave you quite anxious. Small setbacks may leave you with a knot in the pit of your stomach and a sense that something bad is going to happen. Your profile suggests that you're always a little on edge about loss. It's as if you're always worried that something bad is going to happen, leading to losses and setbacks. You feel a constant need to be doing something either to get ahead or to prevent yourself from falling behind.

Sleep or Eating Problems

Your mood instability may lead to sleep problems. When you are feeling wound up, driven, optimistic, and happy, it may be hard for you to fall asleep. When you're feeling down, despondent, and unhappy, you may wake up early in the morning and be unable to get back to sleep. Being driven, pushing yourself hard, and always feeling behind, late, and pressured may lead you to eat without thinking. Perhaps you don't give yourself time to eat, or perhaps you eat too much, resulting in changes in your weight.

Alcohol or Chemical Abuse

You may also try to regulate your mood with alcohol or drugs. You may have found some chemical agent that's particularly helpful in leveling your mood, but this may actually aggravate some of your impulsive and angry behavior. You may be able to drink a great deal without initially appearing drunk, but then you may end up doing impulsive and self-defeating things.

Distractible

Your profile suggests that you're always on edge, looking out for what could possibly go wrong and fretting about missing any potential opportunity. You get distracted and interrupted by thoughts about what you should be doing, how you should be getting ahead, and what you should be achieving. You can also become preoccupied about past losses and setbacks, distracting you from being in the moment. Others' achievements make you feel competitive and drive you to show what you can do.

Cynical or Suspicious

Because you are always worried about loss, you tend to see the glass as half empty. It's as if you're protecting yourself from being too optimistic by reminding yourself of all the things that can go wrong. Others may see you as cynical or even suspicious because you question people's motives and you remind people of all the possible setbacks that could occur in any given situation.

Stimulus Seeking

There is a part of you that always wants excitement, adventure, more success, and even danger. You may find yourself grabbing at opportunities for excitement, sometimes in a self-defeating way. You probably get bored easily, so you're always ready to do something new and exciting, even if you're overloading yourself with commitments or contemplating doing things that may involve excessive risks.

Lifestyle and Background Feedback

Typically, people with your profile grew up in environments where they felt tremendous pressure to achieve and succeed, yet they often felt frustrated. Perhaps your parents expected a great deal from you so that, no matter what you did, it never felt like enough. On the other hand, you may have felt that the odds of success were stacked against you so that you were driven to grab at every opportunity. You go through life pushing yourself to succeed but reminding yourself that things can go terribly wrong. Blowing up, catastrophizing, and pushing and shoving to get ahead would all reflect your fear that if you stay still and be in the moment somehow you will fall behind and lose out.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Code-Type 2-0/0-2

Descriptors

Complaints

Socially withdrawn, sad mood, quiet, sleep difficulties (insomnia and early morning awakening), eating problems or sexual difficulties, feeling unattractive, fearful

Thoughts

Self-critical, guilty, worrying, low self-esteem, fearful of making mistakes

Emotions

Dutiful/responsible, shy, passive, nondemanding, cautious, not expressive, self-contained, sensitive to criticism

Traits and Behaviors

Risk averse, painfully shy, nonassertive, slowed pace, keeps others at a distance, nondemanding, may use alcohol

(Levak, Siegel, Nichols, & Stolberg, 2011)

Therapist's Notes

Individuals who produce the 2-0 code type are quiet and tend not to gossip, they lack curiosity about others' emotional states and motivations, and are apt to be preoccupied with their own interests and needs. They avoid conflict and are uncomfortable with emotional intensity, affection, or praise. They are not hostile, nor are they argumentative. They accept routines, even drudgery, with equanimity and are not ambitious, driven, or political. These clients are apt to be practical, sensible, detail oriented, and conservative. Sometimes they use alcohol as a way of medicating a chronic depression that may be more characterized by a lack of euphoria rather than by acute periods of sadness. These individuals often dress conservatively and are not inclined to take pride in their appearance. As with any profile with Scale 2 elevated, they exhibit symptoms of depression such as sleep disturbance, fatigue, weight changes, lack of pleasure, difficulties with concentration and memory, and anxiety. Happy-moment

milestones, achievements, and successes are not celebrated but, rather, are accepted as the consequences of hard work. When things go well, they see it as temporary, and their default belief is that loss, setback, and humiliation are always possible. Others may see them as sour, negative, and aloof. Predicting that things can go wrong, reminding others not to “count their chickens,” and pointing out the flaws in people’s plans serve as a defense against unpredictable loss and humiliation. If they point out all the negatives, people have less right to blame them when things go wrong. These clients have a slow personal tempo, slowed speech, poor eye contact, low sex drive, low aggressiveness, and a high level of pain and frustration tolerance. In some cases, they may have schizoid qualities and they may even be diagnosed as having Asperger’s syndrome (Ozonoff, Garcia, Clark, & Lainhart, 2005), as painful shyness may inhibit them in certain situations and occupations. They actively dislike intensity, conflict, too much excitement, and open expressions of emotionality. Research on the 2-0 suggests that the profile is stable rather than reflecting a reactive depression (Leon, Gillum, Gillum, & Gouze, 1979). (Levak, Siegel, Nichols, & Stolberg, 2011)

Lifestyle and Family Background

It has been suggested that the 2-0 may have been raised by the equivalent of Harlow’s “wire mother,” that is, primary caretakers who were physically present but emotionally unavailable. In some cases, 2-0 code types were only children with aloof and unemotional, though not cruel, parents, so they developed a self-sufficient and passive personality style, tending to be nondemanding and nonassertive and expecting a low level of interpersonal and social reward.

Our hypothesis is that individuals with a 2-0 profile have a genetic predisposition to shyness, withdrawal, and passivity combined with childhood experiences of parents who were physically available although emotionally and tactilely absent. Their caretakers were not actively malicious and cruelly withholding but, rather, passive, practical, and sensible but without emotional involvement. These individuals have accepted life as it is and have come to terms with a low level of pleasure. As a manifestation of the chronic, low-level depression, the precipitating circumstances for an increase in depression are often a perceived or actual loss. The 2-0 individuals accept higher levels of boredom than most people. Research has suggested that introverts have a high level of base arousal and are therefore arousal avoidant (Eysenck, 1976), which is congruent with how these individuals are described.

(Levak, Siegel, Nichols, & Stolberg, 2011)

This codetype predicts a socially withdrawn, introverted individual with chronic characterological depression. These individuals may manifest a lifelong genetically predisposed shyness, preferring time alone or with small groups of close friends. Symptoms of depression such as insomnia, guilt, and anxiety are almost always present. Often 20

individuals habituate to their low level of enjoyment of life and accept their condition without complaint. The 20 individual often has a phobia or an aversion to large social gatherings. They often feel physically unattractive and have lost interest in making themselves look appealing to others. Others may view them as somewhat colorless or even plain, and lacking in assertiveness. They avoid attention and are often quite passive and conventional, rarely breaking rules. In some cases, this profile reflects an individual who is genetically shy, but was parented by an emotionally aloof caretaker. Phil Marks (personal communication, 1990) has characterized the 20/02 individual as parented by the equivalent of Harlow's wire monkey (e.g. tactile deprivation). Thus, look for childhood histories in which primary caretakers provided adequate basic needs, but tended not to respond to the child emotionally.

If Scales 4 and 8 are below *T*-65, look for caretakers who were adequate, not hostile or cold, but not solicitous and affectionate. The high 20 individuals have extinguished their need for caretaking, for touch, and for being touched by others. Many report disliking physical signs of caring from others. These individuals may have learned to expect little or no emotional or physical contact from others, and may have habituated to this condition. As caregivers, consequently, they have difficulty providing tactile stimulation to their own offspring.

Typically Scale 7 or 4 is the third highest scale. Common among mothers of children receiving psychological treatment, this codetype is often associated with only moderate improvement in the child's psychological condition. The 20 individual tends to keep others at a distance and fears losing emotional control. They may have habituated to a moderate degree of unhappiness and tend not to complain of depression. They lack self-confidence and may complain of insomnia, low energy, and difficulties with cognitive processing. They feel a chronic sense of guilt. Precipitating circumstances for seeking treatment are usually new social situations, where their difficulty in reaching out to others causes them great stress. Teenagers with this profile are particularly vulnerable to social difficulties.

o **Definition:** If the profile is coded 2-0-7-8 or 0-2-7-8, consider interpretation under the 2-7-8 code.

o Mild to moderate depression, usually chronic, with anxiety, anergia, anhedonia, apathy, intropunitiveness, obsessiveness, problems with concentration and memory, low self-esteem, and social avoidance and withdrawal. Schizoid. May complain of insomnia. Feelings of inferiority and a lack of self-confidence; concerns about physical appearance; guilt and self-denigration. Inhibited, schizoid, socially awkward and fearful, timid and underaggressive, and self-defeating. Few or no friends and associates; poor social skills; avoids attention, prefers solitary activities. May be seen as odd. Ideas may seem odd or peculiar because of a lack of consensual validation. Low social visibility. Interpersonally shy, quiet, tense, meticulous, sensitive to criticism or disapproval, uptight, and fearful of emotional involvement. Lacks skills in heterosexual interaction; may be shy and uncomfortable even in marriage.

The outstanding characteristics of this group in Drakes college counselees were problems relating to social introversion.

(Dahlstrom, Welsh, & Dahlstrom, 1979)

2-0 See also the 0-2 combination, p, 232,

1. This combination may indicate a socially withdrawn and introverted person with a mild but chronic and characterological depression. This depression may be related to poor human relations and inadequate social skills. He/she tends to be inhibited, shy, and timid (Webb et al., 1981).
2. VA males with this profile code were found to be socially insecure and withdrawn. They were unhappy, tense, lacked effective social skills, and tended to have insomnia (Hovey & Lewis, 1967).
3. Adolescents in treatment with the 2-0/0-2 pattern (Marks et al., 1974) were nervous and anxious, listless, apathetic, shy, and overly sensitive. They had few friends, and did not enjoy social gatherings. They felt inferior and were viewed by their therapists as schizoid. The Marks, Seeman, and Haller books should be consulted for further information concerning this profile.
4. College students with this profile combination frequently seek counseling (especially men). They are unhappy, introverted, and lack social skills. With a low 1 scale score, women college students may feel physically inferior (Drake & Wing, 1959).
5. Kelley and King (1979a) have found college clients with the 2-0/0-2 profile tend to have academic problems and an inability to choose a career. They were described as indecisive by the counselors.

Description:

Shy, insecure, socially inept, introverted, depression frequently mild and chronic or episodic

Possible Diagnoses:

Depression, Avoidant p.d., Schizoid p.d., Bipolar/Cyclothymic

Modifying Scales

- When Scale 4 is coded third, then these individuals are likely to express more anger, passive-aggression, and subtle argumentativeness. The elevation of Scale 4 would increase the risk of self-defeating and self-destructive acts as well as increasing the likelihood of some kind of addictive behavior.

- When Scale 6 is elevated third, clients are likely to express feelings of being hurt, wounded, and unfairly treated. The depression will be manifested as a sense of feeling victimized, approaching life as a martyr, and feeling unfairly treated and taken advantage of.
- When Scale 7 is elevated third, the profile would reflect an anxious, worried, hyper-responsible individual who, although shy and quiet, is still reaching out to others for reassurance and approval.
- Sometimes the Depression (DEP) is not as elevated as the Scale 2, reflecting a lack of endorsement of obvious face-valid depression items and suggesting that the depression is more endogenous and characterological.
- When Bizarre Mentation (BIZ), Psychoticism (PSYC), or Aberrant Experiences (RC8) are elevated, then look for the possibility of a psychotic depression.
- The 2-0 individuals have difficulty being comfortable with personal disclosure and intimacy, so elevations on the Negative Treatment Indicators (TRT) scale are likely.
- When Cynicism (CYN) or Cynicisms (RC3) is elevated, this would suggest heightened suspiciousness and mistrust.

(Levak, Siegel, Nichols, & Stolberg, 2011)

o **Check:** *INTR, ANX, DEP1, DEP2, DEP3, DEP4, RC2, HEA3, ANG2, CYN1, ASP2* (low), *TPA2* (low), *LSE1, LSE2, SOD1, SOD2, AGGR* (low), *Dr1, Dr2, Dr3, Dr4, Dr5, Hy1* (low), *Hy2* (low), *Hy3, Pd3* (low), *Pd4, Sc1, Sc2, Sc3, Sc4, Ma3* (low), *Si1, Si2, Si3, A, R, MAC-R* (low).

TREATMENT

A depression is often ego-syntonic for the 20 individual. Typically they have adjusted to a low level of pleasure and usually seek help for a specific problem. Moves, new jobs, and new relationships tend to be stressful for them because of their difficulty engaging in social interaction. Assertiveness training, role-playing, rehearsing how to deal with others, and teaching social skills are helpful. Bibliotherapy is helpful, as there are a number of books now available about introversion and how to deal with it without being self-critical. Insight therapy can help them understand how their desire for tactile contact could have been extinguished by growing up in an environment in which caregivers were caring but not emotionally expressive. Educating them on the need for physical stimulation toward their own offspring is often important. In some cases, it is useful to help them engage memories of feeling emotionally alone and help them develop empathy for themselves as children who learned to extinguish tactile responding. If the symptoms of depression are severe enough, they may be open to antidepressant medication. These medications should be administered in small doses, as the 20/02 individual has habituated to a low level of emotional

richness and can find chemically induced psychological changes highly uncomfortable. Mindfulness therapy can be helpful to increase their level of overall satisfaction. Treatments that focus on skill building tend to be more helpful than warm nurturing therapies, which can make them uncomfortable.

o **Treatment:** Structured treatments that focus on social skills and assertiveness are more reliably beneficial than psychotherapy. Responsive to structure, support, and direction, but uneasy with reassurance or praise. Cognitive therapy, antidepressants, or both are helpful for relief of depression and anxiety.

Therapy and Therapeutic Pitfalls

Clients with a 2-0 profile can find intense empathy disturbing and even overwhelming, and they are unlikely to seek psychotherapy with the aim of better emotional health and joyful experience. Typically, they enter therapy either as part of a marital dyad with their partner complaining of a lack of sexual or emotional responsiveness or as parents of children who are acting out in some way. When they do seek therapy, it may be because the depressive symptoms have recently increased due to a recent perceived or actual loss. The therapeutic alliance is slow to develop, but these clients are relatively uncomplicated in that they tend to be sensible, practical and not alienated, unless Scales 4 or 8 are also elevated. Helping them understand themselves as independent, selfsufficient, nonfussy, and nonemotional individuals helps validate their experience. Educate them about how other people feel and need more emotional response. Explain how their personality, a product of both genetics and conditioning experiences, is nonemotionally expressive to help them understand cognitively how they need to change to connect better with others. Support them in their discomfort with emotionality and, at the same time, encourage them to be more expressive, combining rational emotive therapy (Ellis, 1993) with cognitive restructuring (Greenberger & Padesky, 1995). If more intensive therapy is required, help them develop empathy for themselves as children, which might allow them to become more emotionally connected. If the clients' history reveals a stable personality style with limited ability for deeper emotional relationships, then practical, concrete problem-solving advice is suggested (Turner, Beidel, & Cooley, 1997). Therapist support rather than emotional empathy is desirable. Concrete problem solving around specific issues such as assertiveness training (Smith, 1975) tends to be most helpful. In the event of a recent setback or loss, antidepressant medications may be helpful, although the shift in emotional valence may be experienced as uncomfortable.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Treatment and Self-Help Suggestions

1. See if you can identify situations where you have a negative outlook and a tendency to predict that things will go wrong. Work with your therapist to identify any “automatic thoughts” or verbal messages that you say to yourself that are negative or pessimistic.¹ Awareness is the first step toward better problem solving and finding alternative ways of thinking.
2. Relaxation techniques help in overcoming shyness and can help you feel more comfortable when in the company of others. One example of a relaxation technique is controlled breathing, which can be practiced even when in the company of other people. Meditation, yoga, and visualization are also helpful.
3. There is evidence that shyness is an inborn trait; people are born with different levels of shyness. Shyness is also a learned behavior that impacts your social interactions, so it is possible to reverse this tendency by practicing interpersonal skills. *Overcoming Shyness* by M. Blaine Smith (1993) contains practical advice and useful skill building exercises.
4. Resilience building: During times when you feel guilty or isolated, see if you can have more empathy for yourself and focus instead on your strengths such as being dependable and responsible. The Web site www.authentic happiness.com has a questionnaire that will help you determine your “Signature Strengths.” See if you can come up with novel ways to use those strengths.²
5. Because you tend to avoid risks and conflict, it is hard for you to make demands on people. Learning assertiveness skills can help you stand up for yourself and can help you to become more socially confident. Work with your therapist to state your rights and needs in a way that is constructive, direct, and honest.³

¹ *Mind Over Mood* (Greenberger & Padesky, 1995) is an excellent workbook to use in this type of cognitive-behavioral therapy.

² A review of interventions from the field of positive psychology found that using signature strengths in a new and different way each day for 1 week increased happiness and decreased depressive symptoms for 6 months (Seligman et al., 2005).

³ In a study of female undergraduate students, those who received assertiveness training reported reduced levels of fear associated with social criticism and social competence (Rathus, 1972). (Levak, Siegel, Nichols, & Stolberg, 2011)

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you are a thoughtful, circumspect, dutiful individual who tends to follow the rules. You are not an aggressive person or a risk taker. Your profile also suggests that you are somewhat shy. Research shows that shyness is an inherited trait and is not associated with any kind of mental condition. However, shy people can

sometimes find transitions such as moves to a new job or neighborhood particularly difficult. You generally enjoy small groups of people you know well rather than large groups of new people. Small talk can be particularly stressful for you, as can being the center of attention or being called on to speak in a group when you're not prepared. Currently, you seem to be experiencing a period of feeling more unhappy and sad than you would like. You might experience difficulty thinking, concentrating, and remembering. You may also experience periods of low energy and difficulties getting going and being efficient. You genuinely dislike conflict and tend to hang back rather than assert yourself. However, you may recently be feeling as if you're losing out, and you may be quick to feel guilty and down on yourself. People with your profile sometimes grow up in environments where a parent was decent and took care of you, but wasn't particularly expressive or affectionate. Now you may be the kind of person who appreciates being cared for, but you may find displays of affection or warmth or praise towards you difficult to handle. Your therapist may suggest medication to help you sleep and feel less depressed. Medication may help you feel more energetic and better able to think clearly and make decisions. Learn to rehearse with your therapist things you can say when you meet new people and ways you can develop more comfortable social skills. Keep a diary of emotions you experience and discuss those emotions with your therapist so that you are better able to express yourself to close friends. Learn to recognize when you are feeling guilty and self-critical and learn to switch off those negative thoughts. Write lists of positive attributes that you like about yourself and read them when you experience periods of despondency and self-dislike.

Feedback Statements—Elevated Profiles (T-Score > 65)

Socially Withdrawn or Quiet

Your profile shows that you're quite shy and that you prefer spending time alone. While you may enjoy being around other people, you dislike large groups of people that you haven't met before and you tend to stay on the periphery in social gatherings. You prefer small groups of people you know well, and you dislike small talk, so meeting new people can be awkward or even painful. When you do go to parties or other social events, you're very mindful of times that you want to leave and become uncomfortable if you feel dependent on others to leave the social situation. People may see you as a "wallflower" who is somewhat quiet and withdrawn. You don't generally speak up and assert yourself, and you tend not to like to be the center of attention.

Sad Mood

People with your profile are serious, thoughtful, responsible people who feel that life can be difficult and don't expect a high level of happiness and feelings of being carefree. Currently, you may have experienced some increased symptoms of depression with sad, pessimistic feelings. You accept discomfort and frustration as the way life is, but the recent symptoms may have become uncomfortable.

Sleeping, Eating, Sexual Difficulties

You may experience some difficulties with sleep—either getting to sleep or, perhaps, waking up early in the morning and being unable to get back to sleep. You may feel more tired and lacking in energy reserves. Because your profile suggests a low-grade depression, you may also experience some eating difficulties. Perhaps you eat to feel better, or perhaps you find food uninteresting. This may affect your weight, energy, and efficiency. You may also find a diminished interest in sexual activity, so relating to your partner sexually may, at times, feel like a chore or a burden.

Fearful or Worried

You may experience a constant state of mild anxiety or fearfulness. It may not be a link to any specific event. You may just feel a low-grade anxiety, as if something bad is about to happen. You take your life and your responsibilities seriously, and it's easy for you to see what can go wrong.

Self-Critical or Low Self-Esteem

You tend to be your own worst critic. You are quite self-conscious and aware of how you are coming across, but you are likely to be self-critical and see yourself in the worst possible light. You feel that you're not that good, that you're not worthy, and that others may be critical of you.

Dutiful or Responsible

People with your profile are loyal, dutiful, responsible, and reliable. It's very important for you to do the right thing, and you tend to be someone who others trust. You worry about following through with chores and responsibilities, and you don't want to draw attention to yourself as someone who has failed others.

Non-demanding or Nonassertive

You tend not to make demands on people. Even if people mistreat you or take you for granted, you tend not to stand up for yourself and demand what is rightfully yours. It takes a great deal of thinking and resolve for you to assert yourself and to claim what is rightfully yours. Being honored or having a fuss made over you might cause you embarrassment as you prefer to avoid the limelight.

Cautious

You are, by nature, a cautious person, tending to avoid risks and confrontations. You are a thoughtful, circumspect, and serious person who doesn't make rash judgments. These traits are useful in many professions because your careful, thoughtful style prevents big errors.

Non-expressive or Self-Contained

You tend not to express your emotions. Even when you have intense feelings, you express them very subtly if at all, so others may well miss knowing what you are feeling at any given time. Others may see you as very self-contained and may have a hard time knowing what you're feeling toward them and what you want from them. They may see you as aloof and hard to get to know.

Sensitive to Criticism

Others may not realize how sensitive you are to criticism because you are so reserved. You hate negative attention, so it's painful for you if somebody is rebuking you, especially if it is done publicly. It makes you very uncomfortable and, perhaps, even angry when you are criticized.

Alcohol Use

Because your profile suggests some depression and unhappiness, you may find yourself using chemical agents, such as alcohol, as a way of numbing yourself and feeling better. Alcohol may make you withdraw further and avoid relating to others. If you are using alcohol on a daily basis, if you drink alone, or if you find yourself needing alcohol to "feel," discuss this with your therapist.

Lifestyle and Background Feedback

You test as quite shy. Shyness can be an inherited trait, and there is nothing wrong with being shy, especially if you are comfortable being so. You were probably a shy child, slow to warm up in new social situations. Perhaps you were an only child or lived in an environment where there were few opportunities to relate to others. The combination of genetic predisposition to shyness and withdrawal and, perhaps, parents who were available but not emotionally expressive or “touchy-feely” meant that you had to learn to comfort yourself. You may have learned to not need physical affection, being held, touched, and emotionally rewarded. Now you may find it difficult to be too demonstrative or have other people act affectionately toward you. It’s as if you’ve learned to rely on yourself, to nurture yourself, and to not need others’ warmth or touch. Your spouse or children may need more affection and interpersonal touching from you to continue to feel connected.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Scale 3: Hysteria (Hy)

Descriptors

Complaints

Health concerns, weakness or fatigue, sleep difficulties, sexual concerns, and sadness or dysphoria, anxiety or feeling overwhelmed

Thoughts

Positive, denying, need for attention and affection, somatic preoccupations

Emotions

Positive or cheerful, dysphoric and anxious under stress, needy and approval-seeking, repressed

Traits and Behaviors

Conflict avoider and peacemaker, denial and repression of negative emotions, inhibited, lack of insight, conversion disorder

(Levak, Siegel, Nichols, & Stolberg, 2011)

Therapist's Notes

In the normal range, this profile is suggestive of sociable, agreeable individuals who are kind and sensitive to others' feelings. They are often seen as sentimental, conflict averse, and sometimes romantic individuals who do not want to cause others pain. Clients with a high Scale 3 manifest a cluster of symptoms, traits, and behaviors that, in a normal population, are generally uncorrelated. An individual experiencing a number of troublesome somatic complaints would generally show concern, worry, apprehension, and distress about those symptoms. Clients who are elevated on Scale 3, on the other hand, often appear bland and even positive and cheerful in the face of such symptoms. Scale 3 is one of the least homogeneous of the clinical scales, comprising three distinct clusters of items. One consists of a series of items about physical symptoms, such as stomach upsets, weakness, fatigue, and pain. Another cluster describes an outgoing, socially acceptable, and "nice" person who is capable of being pleasant even to people they don't like and of seeing people as well meaning and trustworthy. The third cluster of items deals with feelings of

dysphoria, unhappiness, and periods of sadness and anxiety. Clients who are elevated on Scale 3 likely exhibit a combination of these traits. They are socially appropriate, positive and cheerful in the face of pain, mildly complaining and dysphoric, and motivated by love and approval from others. They are subtly demanding of attention and caretaking from others. From an attachment theory perspective, they can be seen as wanting reassurance about the strength of others' positive attachment to them, almost at any cost, so they deny and repress undesirable emotions. Repressed anger tends to be converted into somatic symptoms, and recent research has shown a link between physical deterioration and emotional stress (Carleton, Abrams, Asmundson, Antony, & McCabe, 2009; Hall, Chipperfield, Perry, Ruthig, & Goetz, 2006). Children from abusive backgrounds develop more physical problems over the course of their lifetime, die younger, and are more likely to develop autoimmune problems in later life (Danese, Moffitt, Harrington, & Milne, 2009). Research with individuals who are elevated on Scale 3 has revealed that physiological breakdown can occur due to severe stress (Larzelere & Jones, 2008). Our hypothesis is that elevations on Scale 3 reflect a preoccupation with the avoidance of emotional pain in response to conditioning experiences of traumatic overloads of pain in childhood. Repression, being positive and cheerful in painful moments, denying negative feelings, and turning a blind eye to unpleasant situations would make adaptive sense as a response to such events. Repression and denial have their psychic costs, however, and may lead to physical breakdown. Physical symptoms can be symbolic of intrapsychic conflicts, often mimicking organic illnesses, making diagnosis difficult and potentially confusing. Individuals with a high Scale 3 are rarely self-referred for therapy but are sometimes referred by physicians unable to find a clear medical diagnosis that fits all the symptoms or by personal injury attorneys involved in a work-related injury. Individuals with this profile have a poor awareness of normal angry, sexual, and self-centered feelings, which tend to be manifested in symbolic ways. When they do express anger, it can be either passive-aggressive or, occasionally, dramatic. (Levak, Siegel, Nichols, & Stolberg, 2011)

Lifestyle and Family Background

As repression, denial, and somatization are primary defenses associated with Scale 3 elevations, look for overloads of emotional pain in childhood with resulting repression and denial. These clients often report early parental loss illness, or rejection, especially involving the father. Typically, these clients responded to childhood emotional pain by being "a brave soldier" to remain pleasing to others and to maintain emotional proximity. In some cases, the Spike 3 is associated with childhoods in which repression and denial were encouraged, perhaps by families where the expression of negative feelings was threatening or viewed, for cultural or other reasons, as unacceptable. (Levak, Siegel, Nichols, & Stolberg, 2011)

A Spike 3 codetype (i.e. no other clinical scale above *T*-65) predicts a conventional individual who has strong needs to be accepted and liked. These individuals can lack self-assertiveness and dislike confrontations and “making waves.” They play the correct social role and are threatened by any loss of social approval. When anger is expressed, it may be done in an inappropriate or impulsive way because it is poorly integrated and breaks through the individual’s denial. Backgrounds associated with a Spike 3 codetype consist of childhood homes that were unhappy, with a parent who could be explosive or episodically rejecting. In other cases, caretakers discouraged the expression of negative affect and emphasized being positive and brave in the face of distress. Because of difficulties with intimacy, the Spike 3 individual may exhibit sexual problems and a tendency to be somewhat dependent.

o Conventional, outgoing, optimistic, and socially confident, but with some general concerns about health and physical functioning or narrowly focused symptoms (e.g., aphonia). May develop somatic symptoms under stress. Responsible, friendly, and trusting, but may be seen by others as immature, self-centered, shallow, and inhibited. Seeks to avoid conflict and unpleasantness; unaggressive. Refuses to recognize problems in self or others.

High-Point 3's The data in the tables in Appendix M indicate that there is a large sex difference in respect to the frequency of scale 3 peaks. In women scale 3 peaks are exceeded in frequency only by the other two scales in the neurotic triad, 1 and 2; in the psychiatric subgroup only scale 2 has more frequent peaks for women. But in male profiles scale 3 occurs rather infrequently among normals and only scale 6 has less frequent peaks in the psychiatric groups.

In Guthrie's data, however, gathered on patients of a general physician, scale 3 peaks were the most frequently obtained among all MMPI profiles.

Particularly dramatic is the frequent occurrence of spikes, that is, elevations on 3 combined with no other MMPI scale within Hathaway's codable range. The selective effect of this personality variable in a medical practice and, possibly, the special circumstances under which these patients were tested may have led to this highly biased sample in comparison with male and female normals. The normal college women in this code group were described by their acquaintances, in Black's study, in rather uncomplimentary terms. This contrasted with the ways in which these college women described themselves on the same checklist. The adjectives found characteristic by peers of women with scale 3 peaks were these: flattering, irritable, religious, and having many physical complaints. They did not, however, apply the terms partial, undependable, energetic, and clever to the high 3 females. In their self-descriptions these high 3 college women described themselves as trustful, alert, friendly, and loyal. They avoided, to a significant degree, using the terms emotional, boastful, suspicious, unrealistic, shy, and conceited. The self-descriptions of these college women seemed to be as self-enhancing as those reported by Hathaway and Meehl for high 3's. However, the

peer ratings of these girls were not as favorable to them, perhaps because the judges in this instance lived with the girls being rated and had a great deal more day-to-day contact with them than the judges in the Hathaway-Meehl study had with the subjects they were rating. When high-point 3 persons in a college setting seek counseling help, Mello and Guthrie reported, they present problems rooted in an unhappy home situation. The prominent pattern involves a father described as rejecting of them, to which the women react with somatic complaints and the men with rebellion or covert hostility. Their specific worries are concerned with scholastic failure, difficulties with authority figures, and lack of acceptance by their social group. These young people, in some contrast to high-point 2's, develop dependency within the therapeutic situation and stay in therapy longer. Taulbee (1958) also noted a relationship between scale 3 elevations in the code and continuation with treatment in a Veterans Administration mental-hygiene population. Although these cases show cathartic release during treatment to a considerable degree, Mello and Guthrie did not find that they achieved much insight. As noted above, Guthrie found in the records of his internist a large number of patients who had this scale as their peak score. These patients presented a clinical picture of anxiety attacks to a greater extent than any other general MMPI type. They suffered from sudden occurrences of tachycardia, palpitation, and headaches. In their backgrounds, home and marital maladjustments appeared prominently, but they did not often show acting-out behavior or psychotic disturbances. Their response to treatment was often good and they profited readily from advice and reassurance. However, many of these patients resented the imputation of personality difficulties and failed to come back for scheduled follow-up visits. When the peak on scale 3 was the only scale in Hathaway's codable range, Guthrie found the symptoms of subjects to be mild, generally involving the circulatory system, the upper gastrointestinal tract, or headaches. There was no evidence of conversion formation in this subgroup of cases. They sometimes complained of feeling nervous and tense but, as could be expected from the pervasive denial shown on the profile itself, did not show or complain about any other neurotic problems. These persons were infrequently referred, either by themselves or other physicians, as being ill or in distress; more often they were seen for a general physical checkup. Drake has noted that college counselees with scale 3 high and scale coded low show aggressiveness and generally extroverted behavior.

(Dahlstrom, Welsh, & Dahlstrom, 1979)

Low-Point 3's

The occurrence of very low scale 3 scores among normals is not as frequent as would be expected by chance alone. The content of the scale items apparently is sufficiently socially desirable to lead to some degree of elevation on this scale for most groups. Consequently, data on low 3 scores are rather meager. There is the additional possibility that the personality characteristics of these people are actually of a kind that would not be well known and understood by

the subject's peers. Preliminary work on this group has been reported by Cantor (1952).
(Dahlstrom, Welsh, & Dahlstrom, 1979)

Description:

Pollyannish, conventional, deny anger, no insight, use somatization, avoidant

Modifying Scales

- A high Correction scale (K) Spike 3 with Overcontrolled Hostility (OH) elevated would reflect greater repression, inhibition, overcontrol, and cheerfulness in the face of pain with rare explosive episodes that are quickly repressed.
- A low K high 3 with Health Concerns (HEA), and/or Somatic Complaints (Rc1) and Fears (FRS) elevated would reflect a more somatic, dysphoric but smiling, and subtly complaining type.
- Scale 4 in the 60 to 65 range or an elevation on Authority Problems (Pd2) would indicate passive-aggression, episodic, subtle acting out, and a tendency to manipulate others with physical symptoms.
- When Naïveté (Pa3) is elevated, look for value rigidity, which is used to control others.
- An elevated Physical Malfunctioning subscale (D3) in spite of a Depression scale (DEP) below T-65 would predict more physical symptoms and feelings of fatigue and concerns about health.
- The relative elevation of the Hysteria (Hy) subscales affects the interpretation of Spike 3 profiles. An individual who elevates on Denial of Social Anxiety (Hy1), Need for Affection (Hy2), and Inhibition of Aggression (Hy5) tends to present as repressed, inhibited, but socially extroverted. In this pattern, Pa3 is typically somewhat elevated, and Anger (ANG), Cynicism (CYN), and Type A (TPA) are low.
- The Spike 3 with elevations on Lassitude-Malaise (Hy3) and Somatic Complaints (Hy4) tends to present as fatigued or exhausted and more manifestly dysphoric and depressed.
- When Bizarre Sensory Experiences (Sc6) or Neurological Symptoms (Nsa2) are elevated, dissociative and unusual symptoms aggravate the somatic symptomatology associated with Scale 3.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Male

Low 0 One interview only, aggressive or belligerent, wants answers or insists on test scores. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, lack of social skills, mother conflict, being nonresponsive or nonverbal, being nonverbal or a nonrelator, being unrealistic or illogical, nervousness, restlessness, unhappiness.

Female

Low 0 Lacks academic drive, marriage oriented, tense on examinations, socially extroverted.

Low 2 Socially extroverted.

Low 5 Distractible in study, exhaustion, insomnia, headaches, home conflict.

Nothing Low Tense on examinations, verbal, father conflict, mother conflict.

(Drake & Oetting, 1959)

o **Check:** *HEA3*, *RC1*, *CYN1* (low), *CYN2* (low), *RC3* (low), *ASP1* (low), *SOD2* (low), *AGGR* (low), *DISC* (low), *Dr3*, *Dr4*, *Hy1*, *Hy2*, *Hy3*, *Hy4*, *Hy5*, *Pa3*, *Si1* (low), *Si3* (low), *A* (low), *R*, *O-H*, *Re*, *MAC-R* (low).

TREATMENT

Assertiveness training, combined with mindfulness therapy to help the individual learn to recognize negative emotions, can be helpful. Supportive, non-confrontational therapies tend to work best. Explore any past childhood experiences where they had to be “brave” and be “good soldiers” in the face of pain.

o **Treatment:** Treatment plan to focus on presenting problem.

Therapy and Therapeutic Pitfalls

Individuals with high Scale 3 scores tend to lack insight, so premature pushing to increase self-awareness may precipitate the anxiety they have spent a lifetime avoiding through repression and denial. They may have difficulty remembering specific painful events of their childhood, so insight can be slow to develop. Catharsis around past frightening events can help them learn to deal with emotional intensity, though they must first learn how to control emotional panic. Having the client visualize mildly upsetting images and learning to relax and self-soothe in the presence of those images would be a useful beginning before introducing past severe losses or traumas. Help them to develop empathy for themselves as sensitive children who were overloaded with emotional stimuli and needing to be brave to please caretakers. Suggesting that physical symptoms are “psychological” would lead to quick

termination. Instead, linking physical symptoms to psychological stress can be accomplished by using a diary to monitor when their physical symptoms increase in severity. Helping them to manage their medical diagnostic process would build a therapeutic alliance and would allow the therapist to eventually point out how physical and psychological issues are linked. Using gestalt techniques, help them express any blocked anger and sadness associated with past painful events. As they become emotionally engaged during the therapeutic process, they may develop various physical symptoms such as lightheadedness, dizziness, or feelings of nausea, which interrupt the engagement of repressed emotions and elicit caretaking from the therapist. Have clients monitor how they feel as they recount an emotional event, teaching them to notice when they repress or inhibit feelings or shift the focus of attention onto physical symptoms, thereby interrupting their experience. The goal of therapy is to make clients comfortable experiencing intense emotions so that they can articulate their feelings without feeling overwhelmed. (Levak, Siegel, Nichols, & Stolberg, 2011)

Treatment and Self-Help Suggestions

1. Whenever you experience moments where you feel mildly irritated, take time to explore whether you could be feeling more anger than you're aware of. For you, anger, resentment, and being demanding of others will tend to be kept under wraps, like an iceberg, mostly below the surface. By the time you are having any of these feelings, they might be deeper than you realize. Force yourself to exaggerate your anger, to "try it on for size," to get a better sense of empathy for yourself. Explore with your therapist moments where you had to be particularly brave and to deny and cover up negative emotions because there was no one there to comfort you.
2. Resilience building: Learn to be more assertive and to ask for what you want. When people make requests of you, don't impulsively agree to them. Give yourself a few moments to think about whether you really want to do it or whether you're just automatically trying to please. When people make a request of you, you can "buy time" by stating that you need to check your calendar first or that you need "time to think about it."¹
3. When you do episodically get angry, realize that other people may be more affected than you thought. Because you tend to not express anger for long periods of time, when you do, it can surprise or frighten people.

4. Watch your tendency to say things to please others. You tend to dodge negative feelings and to identify with being “nice” instead of being real. Trying to please others and ignoring negative feelings may also take a toll on your emotional and physical health. With your therapist, practice saying “no,” practice speaking your mind, and practice taking care of yourself.²
 5. When you experience sadness watching a movie or reading a book, give yourself time to linger with the feeling so that you don’t rush away from it and repress it. This is to help you learn to process negative emotions that you had to hold back because there was no one there to comfort you.
 6. Keep a journal of your physical symptoms and try to see if they can be linked to any events going on in your life at the time. Journal writing in itself is an effective way to manage stress. Develop a writing routine whether it is every day or every few days. If you make journal writing a habit, you will eventually detect the patterns of your thoughts and feelings associated with physical symptoms and can notice trends as to when your symptoms get better or worse. Once you have identified any stressors, write out a plan about ways to cope with the stress.³
 7. Learn relaxation training and meditation to relax and release emotional stress. Progressive muscle relaxation (PMR) is a systematic way of relaxing that is best practiced at least once a day for a week and then can be used as needed but is helpful as a daily practice. The PMR procedure teaches you to relax your muscles by first deliberately tensing a muscle group and then releasing the tension and noticing how the muscles relax as the tension flows away. The typical sequence begins with the feet and works up. You can find a good guide to PMR techniques at www.guidetopsychology.com.
 8. Many types of meditation can help you to relax and to become more accepting of your feelings. There are many forms of meditation, both structured and unstructured, and you may have to experiment to see which works best for you.⁴ You can order books, CDs, DVDs, or meditation tapes from the Stress Reduction Clinic at the University of Massachusetts Medical Center at www.mindfulnessstapes.com or from www.soundstruce.com. One that is easy to practice and has been proven effective is transcendental meditation (TM).⁵ TM is a process that is practiced 15 to 20 minutes twice daily while seated comfortably with your eyes closed. TM is taught in a standardized, seven-step course over 4 days by certified teachers; the center nearest you can be found at www.tm.org.
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¹ Two good books to recommend to your client about assertiveness are *Your Perfect Right: A Guide to Assertive Living* (Alberti, 1982) and *When I Say No I Feel Guilty* (Smith, 1975).

² An excellent book to use with your client is *The Disease to Please: Curing the People-Pleasing Syndrome* (Braiker, 2001).

³ In structured writing about stressors and stressful events, when comparing writing that consisted of exploring one's thoughts and feelings with writing plans to deal with the problem, those who developed plans experienced decreases in stress-related symptoms, and those in the group who explored thoughts and feelings felt more control over their emotions and more confidence in resolving their problem (Lestideau & Lavalée, 2007). This suggests that writing that includes both exploration and plan development would be helpful.

⁴ Jon Kabat-Zinn (1994) has done extensive research on the effectiveness of meditation in stress management; meditations has also been empirically established to help prevent the recurrence of depression (Segal, Williams, & Teasdale, 2002).

⁵ In one study (Eppley, Abrams, & Shear, 1989), TM produced a significantly larger effect size than other forms of meditation and relaxation such as biofeedback and PMR. (Levak, Siegel, Nichols, & Stolberg, 2011)

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you are an agreeable individual who likes to please others and that you are a conflict avoider. You tend to see the best in people, sometimes to the point that you can deny negative things about them to your own detriment. Your tendency is to smile, conform to avoid conflict, and not assert yourself. Consequently, tensions can sometimes accumulate and some people with your profile develop physical symptoms. Low back pain, stomach upsets, headaches, episodic dizziness, nausea, and other vague and shifting physical symptoms may reflect stress that accumulates because you are working hard to please and avoid conflict. Perhaps you grew up with a parent that was episodically, frighteningly angry. Perhaps for some other reason you learned to smile, to not see the negative, and to try to focus on the positives. You may have learned from an early age that you had to be brave and soothe yourself with trying to see the positive in any situation. Work with your therapist at learning to recognize when anger or resentment is building. See if any of your physical symptoms could be tied to some frustration that you are denying. Role-play with your therapist how to get angry with someone and see if you can learn to recognize frustration so that you can manage it more effectively.

Feedback Statements—Elevated Profiles (T-Score > 65)

Health Concerns

Your profile suggests that you may be experiencing a number of health concerns and problems. Perhaps you have occasional headaches, stomachaches, or low back pain. You may experience various pains and weaknesses, dizziness, nausea, fatigue, and other vague and shifting physical symptoms. These symptoms may frighten you and cause you discomfort, but you try to stay brave and positive. Some of these symptoms may be very unnerving, especially if doctors are unable to diagnose what exactly is wrong. What might be particularly confusing is that these symptoms may shift and change, with no one symptom dominating for very long. These physical symptoms may become more severe during times of stress and then suddenly diminish. You may have been to see many doctors, attempting to diagnose the problems without much success. Each doctor may send you to another specialist without any obvious diagnosis. If that has been going on for a period of time, it can be quite scary.

Sleep Difficulties or Sexual Concerns

It may be hard for you to sleep, or you may wake up feeling tired. During the day, you may have periods where you lack energy without any apparent cause. Sometimes people with your profile experience low sex drive, which isn't surprising if you're experiencing numerous physical symptoms of stress. It's hard to relax and enjoy sex if you're worried that there's something wrong with you. Sometimes your sex drive may be affected by anger or resentment that you feel toward the person you're involved with.

Sadness or Dysphoria

You may find yourself sad and experience periods where you feel down, even though you try to stay positive and cheerful to others. It's hard to enjoy life if you're worried that there's something wrong with you or if you experience periods of pain and various physical symptoms. At times, this may lead you to feel hopeless and defeated and afraid that you are going to experience a life of pain.

Anxious or Overwhelmed

Although you try to stay positive and optimistic and you do a good job of playing the right role, underneath you may feel overwhelmed and anxious, especially when your physical symptoms are worse. It may be hard for you to do things for yourself, and you may feel a need to obtain other people's support and help.

Positive or Conflict Avoider

People with your profile try to be positive and brave, even in the face of pain and discomfort. It is important for you to be seen by people as a cheerful and nice person, and you work hard to avoid conflict. You try to see the best in

people, so that sometimes people can disappoint you because you have overlooked or denied their negative attributes. It's important for you to think positively of people, and it's important to you that people like you and see you as a good person. You work hard to get their approval. You try to see the best in others, turning a blind eye to their failings.

Need for Affection and Attention

You are a person who wants affection and attention from others. If someone is angry with you, it is upsetting, and you work hard to gain people's approval. It can be quite unsettling if you think someone doesn't like you, and it's stressful if you have to tell someone off or do something that might leave them feeling rejected.

Repression or Denial of Negative Emotions

You tend to repress and deny some of your negative emotions because it's so important for you to be positive, happy, and cheerful and not to upset the people around you. It's as if you have learned to not feel negative emotions to stay connected and close to people. When you do get angry, it may be a sudden welling up of anger that takes you by surprise, and then others may feel like you are sharp or even harsh with them. Once you get angry, you may not realize the impact you've had on others because you return to being cheerful and happy once you've expressed your negative emotions.

Conversion Disorder

Your profile has been associated with something called a conversion disorder. What this means is that your body is particularly vulnerable to developing symptoms of stress when you are emotionally upset. There is a strong link between the body and the mind, and your body is particularly sensitive to stress. Your physical symptoms may actually reflect a particular conflict or emotional problem you are struggling with. It doesn't mean that your physical problems are "in your head." Rather, research has shown that the body responds to stress in ways that we're not always aware of. Low back pain may indicate repressed angry feelings you are trying to keep down and headaches may signal to you that you're going through a conflicted and stressful time. Understanding how stress and physical problems are linked would be a good thing to explore in your therapy.

Lifestyle and Background Feedback

People with your profile often grew up in families where they experienced some kind of emotional stress or deprivation. You learned to be brave and to numb your feelings to avoid upsetting others. Perhaps you had a parent

who was rejecting or absent, or you experienced periods of emotional turmoil or abuse. In other cases, people with similar profiles experienced a death of a parent with subsequent family dislocations. It's also possible that you grew up in an environment where expressing anger and resentment was not allowed, or perhaps negative emotions were expressed so violently that it frightened you. Your response to emotionally upsetting situations was to stay positive and to not let yourself get too emotionally upset. This was a useful way to deal with those events, but it may have put stress on your body as you worked hard to avoid feeling negative emotions. Perhaps there was no one there to comfort you and make you feel safe, so you worked extra hard to be nice and pleasant. No wonder it's now hard for you to know what you're feeling, if it is negative, so that anger and resentment get bottled up and expressed only infrequently.

Normal-Range Feedback (t-score 50 to 65)

Your profile is in the normal range and reveals a number of strengths. You enjoy people, are kind and sensitive to other's feelings, and like to make those around you feel comfortable and happy. People with your profile typically deal with unpleasant and painful events by trying to stay positive and cheerful. You are an agreeable, perhaps even sentimental and romantic person who wants people to get along and not cause each other pain. Because of your tendency to look at the bright side and to see the best in people, others may sometimes see you as naïve, even childlike. Since you are unwilling to look at the negative, this can leave you vulnerable to being exploited by others. You are uncomfortable when you have to confront someone or be firm or angry with them. It may be hard for you to say things that might hurt people's feelings, so instead you end up doing something nice for them even when you don't really want to.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Relations with Other Scales

Spike 3, High K Code

An elevated *K* scale score suggests a greater need to maintain emotional control and to be seen as socially conforming. The elevation on *K* increases the need of high Scale 3 individuals to present themselves as having control over their lives and being socially exemplary. Characteristically, these individuals approach emotional situations with a determined optimism and a "stiff upper lip." They emphasize good relations and harmony with others, and avoid situations in which anger, disruptions, or hurt feelings are involved. They are often tormented when they have to reject or reprimand someone. When anger is eventually expressed, it can appear clumsy, as a breakthrough of strong and determined feelings rather than in accord with the thoughtful sensitivity that they

generally exhibit.

TREATMENT

The profile reflects a well-defended, socially engaged individual. Look for childhood conditioning experiences where they were frightened by the intensity of their own emotional response to some situation. Questions such as “Do you remember a time in your life when you felt knocked off balance by the intensity of your emotional response to an event?” may engage them in understanding their discomfort with emotional intensity. Some will describe childhood histories of chaos and catastrophe within the family home, where intense emotionality was frightening to them. However, an opposite history is also possible. Individuals who grew up in homes where the expression of strong emotions and upset was discouraged can also develop a strong sense of socially appropriate, repressed emotionality. Psychotherapeutic techniques such as role-playing anger or sadness can help them become more comfortable with a wider range of emotions. Explore any early rejections or emotional traumas that could have conditioned them to avoid expressing negative emotions.

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you go through life with a “stiff upper lip” approach to emotions. You are a poised individual who does not lose your head in a crisis. People have to “multiply” the intensity of what you are saying in order to get a sense of empathy for you. If you say that you are “not too happy,” you might, in fact, be quite angry or upset. It may be that, from an early age, you learned to control your emotions and express them only in socially appropriate ways. Perhaps the expression of intense emotions was discouraged growing up, or perhaps it would knock you off balance when people became emotionally upset. Work with your therapist to learn how to recognize the full range of your emotions and rehearse ways to express them to others without feeling knocked off balance. Explore any memories of experiencing intense emotions and feeling out of control, or watching someone else express emotions in ways that overwhelmed you.

31/13 Code

(see also 13/31 Codes)

In contrast to the 13 codetype, people with a 31 codetype appear more cheerful in the face of their pain. The pessimistic, negative, defeated qualities evidenced in the 13 codetype are reduced and masked by the charming attempts to please and be likable associated with Scale 3.

Rules

3 and 1 above 70 Ts 1 minus 2 more than 10 T-scores

3 minus 2 more than 10 T-scores

3 minus 4 more than 10 T-scores

5 above 45 Ts

7 greater than 8 (or 8 minus 7 less than 5 T-scores)

9 and below 70 Ts

K greater than F, F below 60 Ts

Most Descriptive

56. Complains of weakness or easy fatigability (8.8) +

7. Psychic conflicts are represented in somatic symptoms (8.6) +

9. Presents self as being physically, organically sick (8.4) + +

75. Has inner conflict about emotional dependency (8.4) + +

25. Presents a favorable prognosis (8.2) + + +

20. Complains of difficulty in going to sleep (7.8)

65. Has an exaggerated need for affection (7.8) +

1. Is vulnerable to real or fancied threat; generally fearful; is a worrier (7.6)

2. Demands sympathy from others (7.6) +

82. Gets appreciable "secondary gain" from symptoms (7.6) +

102. Genotype has hysteroid features (7.6) +

105. Manifests hypochondriacal tendencies (7.6) +

5. Possesses a basic insecurity and need for attention (7.4) +

8. Overreacts to danger or makes emergency responses in the absence of danger (7.2) +

69. Gets along well in the world as it is; is socially appropriate in own behavior (7.2) + + +

91. Tends toward overcontrol of needs and impulses (7.2) +

57. Seems unable to express own emotions in any modulated adaptive way (7.0)

Least Descriptive

45. Thinks and associates in unusual ways; has unconventional thought processes (1.0) —

39. Genotype has psychopathic features (1.2) —

40. Genotype has schizoid features (1.2) —

- 42. Is "normal," healthy, symptom free (1.2)
- 106. Has grandiose ideas (extreme is delusion of grandeur) (1.6) —
- 103. Reports difficulty in thinking; can't concentrate (1.8)
- 107. Would be organized and adaptive when under stress or trauma (1.8)
- 104. Delusional thinking is present (2.0) —
- 96. Genotype has paranoid features (2.2) —
- 24. Spends a good deal of time in personal fantasy and daydreams (2.4)-_
- 63. Has a resilient ego-defense system; has a safe margin of integration (2.4)
- 37. Defenses are fairly adequate in relieving psychological distress (2.6)
- 43. Undervalues and consistently derogates the opposite sex (2.6) —
- 11. Is cheerful (2.8) +
- 61. Tends to be flippant both in word and gesture (2.8)
- 19. Is unpredictable and changeable in behavior and attitudes (3.0)

31's

The psychological similarity between the 31s and 13s has been noted by Meehl and Hathaway (1951b) and by Black. The reader should refer back to the section on 13 codes, where the adjectives which the female subjects in Black's study ascribed to themselves and received from their peer ratings were summarized. The similarities between the 13 and 31 patterns were also noted in the medical patient study by Guthrie; the only noteworthy differences were that the complaints of the 31 patients were of the sort "that arrive secondary to protracted periods of mild tension." Conversion hysteria itself in its classic manifestation was rare in this group; the symptoms that these patients showed ranged from headaches, backaches, pain in the chest, and abdominal distress to fatigue that was clearly out of keeping with their recent exertions. It is interesting to note how rarely these patients were fully incapacitated by their symptoms. Note also the similarity of this group to Hanvik's (1951) functional low back pain group. The long-standing tension states of the 31s are associated with insecurity, immaturity, and a proneness to develop symptoms under stress. When the symptoms appear they are relatively restricted and specific both in location and in nature, in contrast to the 13 patients. Their attention in the medical examination is usually focused on these symptoms and is concerned relatively little with their life situation or general emotional disturbance. Their response to treatment is indifferent; they seem stabilized at a marginal level of adjustment. The items that Guthrie found particularly characteristic of this group (see the Co31 scale in Appendix I in Volume II) are mainly characterized by physical symptomatology, but there are a few which deal with social poise and lack of disturbance in relating to others. Cuadra and Reed (1954) note particularly in patients with 31 profiles the

appearance of basic features of a hysterical character, exhibitionism, and repression, together with frank manipulation and exploitation of social relationships. Commenting on the relationships between scales 1 and 3, these authors also note that in those profiles in which scale 1 approaches the height of scale 3 the appearance of conversion reactions is more likely. This latter observation fits in well with the finding of Fricke (1956) on a very carefully selected set of sixty-three female conversion-hysteria cases from the University of Minnesota Hospital files. Hovey (1949) also obtained this pattern for his dissociative-conversion subgroup of cases. The 31 pattern is also included in the Marks and Seeman Atlas as the 3113 code type (see Chapter 3 for the defining characteristics of this pattern).

(Dahlstrom, Welsh, & Dahlstrom, 1979)

3-1 See also the 1-3 combination, p. 87; the 3-1-2 Triad profile, p. 136.

1. In contrast to the 1-3 combination, people with a 3-1 pattern tend to have symptoms that are relatively specific and of a somewhat more episodic nature. They tend to have a long history of insecurity and immaturity. They also tend to develop physical symptoms when stresses increase (Guthrie, 1952).
2. Because people with a high scale 3 tend to deny that things are going badly, the whining and complaining about physical problems typically seen in persons with high scale 1 scores is modified when the 3 scale is higher than the 1 scale (Carson, 1969). People with this scale combination tend to try to charm people into taking care of them with their illnesses rather than coercing people as those with a 1-3 combination tend to do.
3. The lower the 2 scale, the more adapted the person has become to his/her problems.
4. Marks, Seeman, and Haller (1974) found this 3-1/1-3 pattern, in a university hospital and outpatient clinic. This profile tended to be of a female. A woman with this profile usually had a somatic complaint. Her behavior could best be described as agitated, depressed, and confused, with periods of weakness, forgetfulness, and diuiness. The Marks, Seeman, and Haller book should be consulted for further information concerning this profile.

Diagnosis

Psychoneurosis 77%+++	Conversion/psychophysiologic
Psychosis 14%-	Mixed

Personality disorder 5%	Dependent
Brain syndrome 5%	Acute

Personality Disorder

The predominant clinical features presented by these patients correspond to what has become characterized as "the conversion V" formed by the three scales of the so-called "psychoneurotic triad (scales 1,2, and 3). These are the features subsumed under the heading conversion reaction or (in the revision of the Diagnostic Manual of the American Psychiatric Association, 1968) Hysterical neurosis, conversion type. The classical picture, then, is one in which these patients present themselves as physically ill, while denying that their symptomatology is an expression (i.e., a conversion) of psychological conflict. Under the influence of psychoanalytic thinking, the symptoms are sometimes said to be "speaking" in a symbolic "body language." The mechanism of repression is commonly regarded as the major defense. Weakness and easy fatigability are frequently heard complaints. Other symptoms include back pain, headache, neurasthenia, dizziness, numbness, paresthesia, blurred vision, tremor, genital pain, insomnia, and anorexia; 25% of these women have had hysterectomies. It should be noted that although the classical symptoms of hysteria affect the voluntary muscles, a number of these patients suffer gastrointestinal disturbances such as nausea, vomiting, and ulcers. These are likewise reported by Gilberstadt and Duker (1965) and suggested by Lewandowski and Graham (1972). The clinicians who studied this group concur in the general notion that hysterical patients garner considerable secondary gain from their symptoms. The 3-1 patients are characterized as demanding sympathy, and harboring considerable needs for attention (needs correlated with basic insecurity), as well as exaggerated needs for affection. At the same time, their emotional dependency is seen as a source of inner conflict for them.

As reported by other clinicians studying hysterical patients, we found that they differ from the modal patient in that they are generally socially adaptable and socially appropriate; they are also viewed as "getting along well" in the world outside the hospital. Nevertheless, their emotions are not well modulated and there is a certain exaggerated, histrionic character which colors their behavior.

The 3-1 patients also deviate from the modal psychiatric patient in the

obvious intactness of their logical thought processes as reflected in their stream of speech. This is the type, for example, which serves as the anchor at the low end of the 1 to 9 Q-sort scale on the statement "thinks and associates in unusual ways, has unconventional thought processes"; for these patients to obtain a mean rating of 1.0 requires the unanimity of at least five clinicians' opinions. Thinking difficulties and concentration difficulties are also virtually absent. These patients do, however, tend to be forgetful and appear perplexed. The role of genetics and its contribution to disturbed behavior and disturbed functioning is not well understood-certainly not agreed upon. Nevertheless, in the case of this functional disorder, there appears to be substantial agreement in the emphasis on environmental factors. Gottesman's (1962) study using a large number of monozygotic twins reports a small genetic loading-a finding consistent with this view of the primary contribution of learning. The personal history of these patients demonstrates this as well. Although the age of onset of disorder is 47 years (one of the oldest of all groups studied), previous episodes were reported in 75% of the cases. As children, 30% of these patients were ill and 30% had mothers who were also ill. In fact, death of one or both parents was noted in 60% of all cases (40% father, 35% mother).

TREATMENT

See treatment section under the 13/31 codes.

THERAPEUTIC FEEDBACK LANGUAGE

See feedback section under the 13/31 codes.

312 Code

This is one of the two patterns known as the "conversion V" (the other is the 1-3-2 pattern). Interpretation of this pattern is similar to the 1-3-2 pattern with some modifications. When the 3 scale is higher than the 1 scale, the person tends to be optimistic about his/her physical symptoms, instead of pessimistic about them as people with the 1-3-2 pattern are. These people play down their physical complaints, and they also deny that the physical complaints may have a psychological basis. Thus, they tend to be difficult in therapy. The physical complaints of this group in general are more specific and less global, in contrast to the 1-3-2 pattern. (See also the 3-1 combination, p. 126.)

32/23 Code

(see also 23 Code if Scale 2 is within five T-Score points of Scale 3)

In contrast to the 23 codetype, the 32 individual evidences less overt depression and more health concerns, along with repression, inhibition, and strong needs for social approval. A smiling depression with complaints of fatigue, gastric upsets, headaches, and dizziness are common, although various other physical complaints may also be present. The depression is masked by the repression, manifesting as more vegetative symptoms. Actual physical breakdown can occur after prolonged periods of psychological stress. While individuals with this codetype complain of anxiety, they also reveal symptoms of depression, with difficulties in concentration, memory, and generally being efficient. Even though they have physical complaints, these individuals are ambitious, conscientious, and take their responsibilities seriously. It is important for them to appear socially acceptable, and some may appear prudish. They tend to lack insight, and though reassurance about their physical concerns can be helpful, it is often difficult to engage the 32 individual in personality changing psychotherapy. For men, Scale 1, 8, or 9 is most often the third highest scale.

Women with 32 codetypes often report marital difficulties, although divorce tends to be rare. Although dutiful wives and mothers, they tend to be sexually inhibited and report decreased sexual enjoyment. This is not surprising since the 32 codetype reflects repression in addition to depression, which is associated with low sexual drive. The 32 individual is sensitive to criticism or rejection, and can become co-dependent to avoid rejection. In spite of their accomplishments, they often feel inadequate and suffer from self-doubt. Fatigue and exhaustion, perhaps associated both with the repression and the depression, are typical, as are insomnia, complaints of pain, headaches, stomach upsets, and other vague physical symptoms.

32's

The most direct information on the 32 pattern comes from the observations of Guthrie on patients seen by a general practitioner. These patients showed a wide variety of complaints, usually rather mild and rather clearly related to anxiety. Epigastric distress was the most frequent symptom. The complaints of several of these patients shifted to headaches a few months later. Guthrie reported that the usual contact with these patients was a single interview without follow-up or further treatment. The patients that returned typically continued to visit the physician very frequently. They showed a change in the nature of their symptoms with relatively little shift in the severity of their difficulties. The women in this group had a history of marital difficulties but no divorces were reported in their records. They were frequently sexually frigid and were lacking in any desire for sexual relations with their husbands. They complained about the infidelity or drinking of their husbands. This profile pattern, more

than other code types, seems to be related to menopausal difficulties. Hysterical attacks were also frequent in this group, characterized by episodes of fear, palpitation, sweating, insomnia, and abdominal pain. The women showed signs of fatigue and exhaustion as well. They were apparently very conscientious in their work, easily hurt by any criticism or rebuff. In the MMPI profile, the values of the neurotic triad ranged high, with elevations on L and markedly low scores on scale 5. Men with 32 profiles were frequently diagnosed as being in a state of anxiety, and they showed the physical effects of prolonged tension and worry even more clearly than did the women. Their concerns centered around business problems: they were both ambitious and conscientious, taking their responsibilities very seriously. They had episodes of palpitation, dizziness, and being unable to concentrate. Gastric distress was frequent and several gave evidence of having ulcers. They profited from the reassurance given about their physical condition and did not very often return. In his item analysis, Guthrie found (see the Co32 scale in Appendix I in Volume II) that some of the statements characteristic of this subgroup bore upon specific physical complaints, while many of the others dealt with social conformity and denial of either social insecurity or unacceptable impulses. These patients seem to lack insight, to be resistant to psychodynamic formulations of their problems, and to manifest little motivation in seeking psychological help for their problems. The Marks and Seeman Atlas includes data on the 321 code type (see Chapter 3 for the defining characteristics of this pattern). (Dahlstrom, Welsh, & Dahlstrom, 1979)

3-2 See also the 2-3 combination, p. 101: the 3-2-1 Triad pattern. 137-

1. Women with the 3-2 combination tend to have a history of marital difficulties, but no divorces (Guthrie, 1949).
 - a. They frequently are sexually frigid and not interested in sexual activity with their husbands.
 - b. They tend to complain about the infidelity and drinking of their husbands.
 - c. They tend to be conscientious and easily hurt by criticism.
2. Men with this pattern tend to be ambitious and conscientious (Dahlstrom et al., 1972; Guthrie, 1949).
 - a. They may have much anxiety and show the physical effects of prolonged tension and worry. One of the main areas of concern for these men is their work.
 - b. They may have stomach problems which could result in ulcers.
3. Internal medicine patients with this combination tended to see the physician for only one visit. For those who did continue treatment, their physical symptoms did not change. Even though the 2 scale is elevated, little depression was evident. They seemed to be insightful, non-introspective people who were very resistant to psychotherapy (Guthrie, 1952).

TREATMENT

The 32 individual tends to be self-sacrificing and, therefore guilt-inducing, which tends to anger those around them. Consequently, their children can become angry and resentful, especially in adolescence. Antidepressants are often quite effective, though the 32 individual is vulnerable to developing side effects. Relaxation training and assertiveness training are also useful. Beware of anxiolytics, which should be used with caution, as these individuals are vulnerable to dependency. If the *L* scale is elevated, there may be more extreme denial, moral rigidity, and a high degree of concern about being labeled as psychologically “ill.” Any criticisms of other doctors to their current therapist should alert the therapist that they are experiencing frustration with him/her. These individuals have difficulties with asserting themselves and confronting transference issues. The focus in therapy tends to be on physical symptoms or on problems with their spouse or children. Gestalt therapy can help by having their physical symptoms “do the talking” as a way to get them to vent repressed anger and sadness about past hurts and losses. Childhood histories of an early death of a loved caretaker are common. The 32 codetype may reflect a repressed mourning process. The individual may have had to be brave in the face of loss and therefore unable to access the anger and sadness associated with it. Help the individual role-play being assertive or angry and, at the same time, practice relaxation techniques to decondition them to the panic they feel when they express intense negative emotions. In some cases, insight therapy can help them develop a sense of empathy with themselves as children dealing with a painful loss by having to be brave and positive in the face of pain.

THERAPEUTIC FEEDBACK LANGUAGE

See the 23 codetype. Your profile suggests that you are a dutiful, responsible, conflict avoider, whose tendency is to be agreeable and positive, even in the face of pain and physical concerns. Your profile suggests that you may be experiencing physical symptoms such as headaches, stomach upsets, low back pain, dizziness, and other vague symptoms that you are dealing with by bravely attempting to stay positive. You dislike conflict and you’ll go the extra mile to avoid hurting another’s feelings. It is hard for you to give yourself permission to let go and enjoy life, and you have a strong sense of responsibility and duty. You may be experiencing some symptoms of depression, such as difficulties with sleep, changes in your appetite, and a decrease in your sex drive. It is easy for you to feel guilty unless you’re always taking care of others and your responsibilities. You may have experienced the early death or illness of a loved parent. Perhaps you had to stay positive in the face of pain, and you felt you had to be brave and be a “good soldier” so that you would not upset people around you. You may have continued in the role of taking care of others, sometimes at your own expense. Work with your therapist to learn to be more assertive and to recognize that when you are experiencing physical symptoms, they may be at least partly related to stress. You may

also be stressed or tense about some interpersonal issue. Explore any past losses where you felt you had to be brave and shut down your emotions so as not to be negative and upset at those around you. Medication can help with some of your physical symptoms and help you with your overall energy and mood.

321 Code

The addition of Scale 1 to Scales 3 and 2 increases the hypochondriacal complaints and physical symptoms in response to stress. Constipation, diarrhea, anorexia, insomnia, muscle tension, genital pain, palpitations, and exhaustion are common. Almost every physical system, including musculoskeletal, gastrointestinal, cardiorespiratory, and genitourinary, tends to be involved. Depression and anxiety, with feelings of inferiority and hopelessness, are typical. Sleep disturbance and weight problems are common. People with this profile deny socially unacceptable impulses, particularly aggressiveness and the rejection of others.

These individuals tend to lack insight, which can lead them into self-defeating, codependent relationships. They suffer from guilt and can be intropunitive. If Scale 8 is also elevated, there is even more difficulty with cognitive functioning. Memory and difficulties with concentration and problem solving, as well as difficulties with history reporting, are typical. If Scale 9 is below *T*-50, the patient will complain even more of low energy and loss of drive. The 321, low 9 individual likely suffers from weight problems and feels “burned out.”

The female 321 individual often reports gynecological problems and a large proportion of the Marks and Seeman (1963) sample (60 percent) had hysterectomies. The 321 was often a middle child and reported parental domination with strict discipline. Maternal relations are affectionate, but the mother is reported as strict and controlling. The 321

woman presents as tearful, crying, anxious, and depressed, with feelings of inferiority.

Men with this codetype complain of gastric distress.

For both men and women, marital problems are likely, centered on conflicts over sexual intimacy and low sexual frequency. 321 individuals often were above average in school achievement. Many report a history of taking care of an ill parent.

o Weakness, fatigue, and stress-related gastrointestinal symptoms. Dysphoria. Prone to taking invalid role in family. Look for sexual inhibition, a history of gynecological complaints and surgery (e.g., hysterectomy), problems with weight, and insomnia. See *1-2/2-1*, *1-3/3-1*, and *2-3/3-2*.

Rules

3, 2, and 1 above 70 Ts

2 greater than 1 (or 1 minus 2 less than 5 T-scores)

3 minus 1 less than 15 T-scores

3 minus 2 less than 10 T-scores

7 greater than 8 (or 8 minus 7 less than 5 T-scores)

7 and less than 3, 2, and 1

9 and below 70 Ts

L, F, and K below 70 Ts

Most Descriptive

93. Exhibits depression (manifest sad mood) (8.8) +

20. Complains of difficulty in going to sleep (8.2) +

103. Reports difficulty in thinking; can't concentrate (8.0) +

26. Reacts to frustration intropunitively (t.e., punishes self) (7.8) +

68. Keeps people at a distance; avoids close interpersonal relationships (7.8)

1. Is vulnerable to real or fancied threat; generally fearful; is a worrier (7.6)

7. Psychic conflicts are represented in somatic symptoms (7.6)

56. Complains of weakness or easy fatigability (7.6)

102. Genotype has hysteroid features (7.6) +

55. Has feelings of hopelessness (7.4) +

57. Seems unable to express own emotions in any modulated adaptive way (7.4)

40. Genotype has schizoid features (7.2)

85. Has inner conflicts about sexuality (7.2)

92. Is self-defeating; places self in an obviously bad light (7.2) + +

96. Genotype has paranoid features (7.2)

21. Has multiple neurotic manifestations (7.0) +

100. Obsessive thinking is present (7.0)

105. Manifests hypochondriacal tendencies (7.0) +

Least Descriptive

11. Is cheerful (1.0)

42. Is "normal," healthy symptom free (1.0) —

- 107. Would be organized and adaptive when under stress or trauma (1.2) —
- 59. Is socially extroverted (outgoing) (1.6) —
- 63. Has a resilient ego-defense system; has a safe margin of integration (1.6)
- 49. Appears to be poised, self-assured, socially at ease (1.8) —
- 25. Presents a favorable prognosis (2.0) —
- 106. Has grandiose ideas (extreme is delusions of grandeur) (2.0)
- 4. Has a need to think of self as an unusually self-sufficient person (2.2) —
- 41. Has good verbal-cognitive insight into own personality structure and dynamics (2.4)
- 67. Is able to sense other person's feelings; is an intuitive, empathic person (2.6)
- 30. Has "diagnostic" insight; awareness of the descriptive features of own behavior (2.8)
- 61. Tends to be flippant both in word and gesture (2.8)
- 108. Has the capacity for forming close interpersonal relationships (2.8)
- 19. Is unpredictable and changeable in behavior and attitudes (3.0)
- 31. Has a high aspiration level for self; is ambitious; wants to get ahead (3.0)

3-2-1 See also 3-2-1 Triad profile, point 1b, p. 137.

1. Patients with this pattern may have periodic hysterical attacks with palpitations, sweating, fear, and exhaustion (Lachar, 1974).
2. For a woman, this pattern tends to be a hysterectomy or gynecological complaint profile. Typically, she has had a life-long history of ill health. Women with this pattern rarely date and usually are sexually inhibited. If they do marry, they may be sexually frigid (Caldwell, 1972).
3. Women with this profile may be quite involved with their parents in a symbiotic fashion. Frequently, these women report that their mother has physical problems about which the mother does not complain (Caldwell, 1972).
4. Marks, Seeman, and Haller (1974) found this 3-2-1 pattern in a university hospital and outpatient clinic. The pattern usually was for a woman who was described as anxious, tense, depressed, and tearful with somatic complaints. These researchers also found a high probability of hysterectomy and gynecological complaints. The Marks, Seeman, and Haller book should be consulted for further information concerning this profile.
5. The 3-2-1 slope in general is associated with females and is commonly called the "hysterectomy profile." As its name implies, females with such a pattern usually present gynecological complaints.

- a. At the lower levels (solid line) (scales 3 and 2 above 70 and scale 1 below 70) women may report marital difficulties such as frigidity, lack of sexual desire, and husbands with infidelity and drinking problems. (See the 3-2 combination, pp. 126-127.)
- b. At the higher elevations (dashed line) with all three scales above 70, a history of female operations is quite common. These women may be aversive to sex, have a life-long history of ill health, and may have symbiotic relationships. (See also the 3-2-1 combination, p. 127.)
6. Males rarely have this profile. However when they do, the scores are usually at the lower levels. Such men usually have physical problems as the result of prolonged stress and worry.

Diagnosis

Psychoneurosis 39%	Psychophysiologic
Psychosis 35%	Depressive
Personality disorder 17%	Passive-aggressive
Brain syndrome 9%	Chronic

Personality Description

The most prominent feature of patients with this profile is manifest depression expressed in feelings of hopelessness, feelings of inferiority and

perplexity. As might be expected of scale 3 and scale 1 elevations, hypochondriacal tendencies and complaints are characteristically observed.

Seventy per cent have somatic symptoms ranging from back pain, stiffness, weakness, tremor, hypertension, fatigue, blackout spells, and blurred vision to constipation, diarrhea, nausea, vomiting, genital pain, anorexia, and weight loss. About 40% of these patients are diagnosed as suffering from psychophysiological disorders; a considerable number are also characterized as basically hysteroid in personality makeup.

One of the most frequent areas of manifestation of the disorder is sexual.

Sexual delinquency is reported with high frequency as is sexual difficulty. Twenty per cent of these women have had abortions and 60% have had

hysterectomies! It is no wonder that genitourinary discomfort is often one of the presenting symptoms and complaints. Disturbances of sleep is commonly observed in patients who generate this profile. Thinking and concentration difficulties are also frequently heard

complaints. Typically, these patients react to frustration in an intropunitive manner—punishing themselves consistently rather than blaming others. They are seen as self-defeating and prone to placing themselves in an obviously bad light. Easily threatened, these individuals might be characterized as emotional and unable to tone down or modulate their behavior. Adjectives frequently applied to them include tense, anxious, and nervous.

Although scales 3,2, and 1 are the most elevated (and thus define the code), scale 7 is commonly above 70 T-scores (and may in fact be the highest or among the highest scales) for patients of this type. Consequently, our 3-2-1 patients were characterized as obsessional, as well as compulsive and perfectionistic. The terms "schizoid" and "paranoid" also are applied to these individuals. Close personal relationships appear to present problems for these patients who tend to keep others at an emotional distance. Thus, about 65% are indicated to be withdrawn.

These patients tend to come from families where the father is dominating and strict and where the mother, although affectionate, is also said to be strict. Ten per cent of the fathers were physically ill and another 10% were mentally ill during the patient's childhood. Most often, these patients were middle children (67%); another 20% were only children. School achievement was generally above average and more than one-third of the patients with this profile were educated beyond the high school level. This group presented the highest mean IQ on the Shipley (115).

Eighty per cent of these patients are seen on an inpatient basis, and 63% have had previous episodes of one sort or another. Although the prognosis for these women was considered generally quite good at the time of the study, subsequently about 25% committed suicide while in the course of outpatient treatment. In each such instance the suicide was obviously unpredictable and the patient was over 45 years of age. Marital status seemed to have little bearing on this outcome.

TREATMENT

321 individuals have internalized strict parental rules and inhibitions and an uncompromising moral code. Intimate relations appear to present the biggest problem for these individuals, who crave closeness, yet are afraid of it. The focus of treatment should be on helping them process past losses and become comfortable with the expression of

anger and sadness related to those losses. Mindfulness therapy can help them become more aware of their emotions and learn to express them more directly. Role-playing celebration or joy or bragging about a particular achievement can help them engage positive emotions that they have unconsciously numbed. In women, if Scale 5 is low, there is even more passivity and a fear of masculine aggressive sexuality. If Scale 0 is elevated, the individual tends to be even more of a “homebody.” Usually people with this profile are relatively successful because of their conscientiousness, unless their subservience interferes with job advancement.

34/43 Codes

Code-Type 3-4/4-3

Descriptors

Complaints

Relationship difficulties, sexual difficulties, anger problems, somatic symptoms (stomach upsets, low back pain, headaches) gynecological problems (women), alcohol or substance abuse, sometimes paranoid features

Thoughts

Perceptive or reads people well, good role player, rose-colored glasses, approval seeker or conformist, doesn't trust, rebellious or dislikes being controlled

Emotions

Mixed emotions, sensitivity to rejection, can't reject others, unaware of negative feelings, explosive, denying, appears labile, impatient

Traits and Behaviors

Charming or likeable, role player or salesperson, tells white lies, conflict avoiding, explosive, moody, dissociative, sometimes violent

(Levak, Siegel, Nichols, & Stolberg, 2011)

Therapist's Notes

In the normal range these individuals are socially skilled, play the correct role, and tend to look at the bright side of things. They are outwardly conformist and steer clear of direct confrontation, yet are subtly resistant to authority. The normal range 3-4 code types are often seen as attractive, charming, and somewhat seductive. They gravitate toward sales professions where their ability to read people and play the right role is rewarded.

The elevated 3-4 code types have a contradictory and mixed pattern of defenses. On the one hand, their elevation on Scale 3 suggests a drive for emotional connection, emotional support, and the elicitation of caretaking behavior from others and indicates repression, inhibition, denial, and approval-seeking while Scale 4 suggests self-protective emotional distancing, mistrust, alienation, and impulsive acting-out behavior. The intense mixed and ambivalent feelings engendered by the coexistence of these two types of defense systems means that the individual experiences internal tension. This conflict can manifest itself in somatic symptoms and the 3-4s can complain of low back pain, upset stomach, headaches, neck aches, and other vague an interplay of needs for closeness and connection and needs for protective distance and immediate impulsive tension reduction. These clients play the correct part to gain approval and emotional connection, but then have difficulty trusting it even when it is given. They go through life acquiescing, trying to fit in, and fulfilling others' needs until stress accumulates, and they act out, feeling controlled by the expectations that their role-playing engendered. They are very sensitive to disapproval and rejection and, accordingly, have trouble asserting themselves directly. They are able to tell white lies in order to maintain connection and avoid disapproval.

Outwardly, they are conformists who are alert to the rules of etiquette and social propriety, but then they can be subtly manipulative and devious, rebelling against being restricted and then covering their tracks. Their role-playing can create an emotional double life, and their assumption that others are similarly duplicitous, i.e. a projection of their role-playing onto others, leads to occasional heightened distrust of others. Their interpersonal suspiciousness can also be aroused when other treat them with "kid gloves" or avoid them because of their sensitivity to criticism; in rare cases they can experience paranoid episodes.

When Scale 3 is significantly higher than Scale 4 (greater than 10 T-score points), there is less overt hostility and acting-out behavior. The repressive and conforming features of Scale 3 are more prominent, while the self-centeredness and acting-out associated with Scale 4 is less evident. As stress and tension build, these individuals can lose control and exhibit explosive behavior but then have dissociative spells with little awareness of their behavior or its effect on others. If Scale 4 is equal to or higher than Scale 3, acting-out behavior is more likely; although they want to be seen as patient and appropriate, they can irritable and derisive. With this combination of scales, the anger and impatience of Scale 4 is muted and tempered by the need for social acceptability of Scale 3. These clients may deny being angry but their temper may be expressed through joking and sarcasm. In some cases, especially if Over-controlled Hostility (OH) is elevated, angry outbursts can be physically aggressive and even dangerous.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Lifestyle and Family Background

In relationships, these clients have difficulty letting down their emotional guard and being vulnerable, reflecting their fear of trusting. They often have marital relationships that are characterized by sensitivity to criticism and a quickness to feel hurt and angry if in any way rejected. They tend to be quite demanding and sometimes verbally or even physically assaultive, especially if OH is elevated. At times, the 3-4 individuals can become so tense, due to the operation of strong contradictory emotions, that they complain of depression and dysphoria; they may experience occasional anxiety attacks as repressed emotions reach consciousness. These individuals can experience severe agoraphobia, reflecting their fears that they will be overtaken by impulses, rendering them out of control. Even though they are often seen as attractive by the opposite sex, they may become quite inhibited sexually over the course of the relationship as their fears of emotional closeness and abandonment emerge. Conceptually, this code type exhibits an ambivalent attachment. These individuals crave and seek love and approval but, at the same time, don't trust it and won't allow themselves emotional vulnerability. Their ambivalence is an adaptive response to a parental figure's unpredictable behavior toward them. A parent may have been emotionally close and nurturing followed by periods of angry, unpredictable rejection when the child did not meet the parent's narcissistic needs. (Levak, Siegel, Nichols, & Stolberg, 2011)

The 34 codetype predicts different personality attributes than the 43. However, the similarities between the two codetypes warrant discussion. Both represent emotional instability, as one would expect in the interaction between hysterical control and emotional alienation and impulsive behavior. The behavioral instability and impulsiveness suggested by the elevation on Scale 4 are modified, controlled, inhibited, and masked by the needs for approval, closeness, and validation suggested by elevations on Scale 3. The relative strength of each of those contradictory drives characterizes the similarities and differences between the 34 and 43 codetypes. Elevations on Scale 3 higher than Scale 4 would predict more overcontrol, with rare, but episodic, impulsive breaking through of strong feelings and impulsive behavior. A higher elevation on Scale 4 would suggest an edgy, poorly controlled anger with a veneer of social correctness, but more impulsive acting out. A major characteristic of both codetypes is anger and acting-out behavior. In both codetypes there are strong needs for nurturance and care from others, but also fears of closeness and needs for independence. 43 individuals are demanding of others and have high needs for validation, and yet find the demands of mutuality taxing. People with both of these codetypes place emphasis on superficial aspects of their lives and are very sensitive to social disapproval. The 34 individual is charming, but quick to feel impatient, and is subtly demanding. The 43 individual is more manipulative and uses charm to get what he or she wants. In some

cases both codetypes manifest mild episodic psychosomatic complaints that reflect overcontrol and can be manipulative.

With a 43 codetype in which Scale 4 is 8 or more *T*-scores higher than Scale 3, anger is more easily and impulsively expressed. The 43/34 codetypes are associated with individuals who can, when provoked, be aggressively hostile, particularly if alcohol is involved. Angry outbursts by the 43/34 come as a buildup of internal pressure. Once anger is expressed, the individual can return to periods of socially appropriate and controlled behavior, and the outburst tends to be rationalized and even denied. Both codetypes suggest egocentricity and immaturity as well as anger. They are both predictive of marital difficulties, sexual acting-out behavior, divorce, and generally unstable relations with others. Many have problems with substance abuse. People with both codetypes tend to be role-players who try to “fit in” socially and seek approval from others. They tend to selectively report and subtly manipulate others into giving them approval. Sometimes this is achieved through flattery and the eliciting of approval by giving it. Often they appear quite conformist on the surface, yet their rebelliousness is manifested in subtle acting-out behavior, and in socializing with more overtly nonconformist individuals. Beneath their control they show an impatience and criticalness of others, masked by a socially appropriate veneer. Individuals with the 34/43 codetype are quite sensitive to rejection and will respond angrily. They tend to project their own sensitivity to rejection onto others, so they have difficulty with the direct rejection of others. Hostility, especially in the 34, tends to be expressed in symbolic, roundabout ways, such as talking behind people’s backs or expressing it in a sarcastic or joking way. This passive-aggressive style is captured in the statement, “I wouldn’t tease you if I didn’t love you.” In spite of an underlying anger towards authority figures and the established way of doing things, people with 34/43 codetypes tend to be rule conscious. When Scale 3 is higher than Scale 4, acting out is sometimes denied, so the individual may actually dissociate from his or her acting-out behavior.

Women with these codetypes often place great emphasis on superficial aspects of their life and are impatient and demanding. They are unlikely to seek treatment unless experiencing a recent rejection or some intense frustration, but they tend not to seek insight therapy.

34/43 individuals value their physical appearance and are often fastidious and seductive dressers. In some cases, transitory paranoid episodes are associated with both codetypes. This is not the fixed, rational paranoia associated with Scale 6 or the sensitive emotional disintegration associated with Scale 8. Rather, it reflects a profound distrust in others that is a projection of the 34/43 individual’s tendency to role-play. They occasionally experience panic around who to trust, and project their own manipulateness onto others.

If Scale 1 is also elevated, the individual shows somatic symptoms, with a tendency to use them for secondary gain. If Scale 2 is elevated, depressive symptoms are expressed as tension and a sense of feeling trapped, bitter, resentful, and defeated. Depression may be due to the consequences of some recent acting-out behavior. It can often be self-medicated through impulsive self-defeating behaviors and addictions. If Scale 9 is elevated, energized, approval-seeking behaviors increase, with a tendency to flatter others and to seek approval through increased social role-playing. The likelihood of explosive behaviors increases.

For men, Scale 2, 5, or 6 is most often the third highest scale.

For women, the third highest scale is Scale 2, 6, or 8.

Adolescents with 34/43 codetype are often referred for treatment because of conflicts with family and school authorities.

- o Chronic, intense anger; harbors hostile and aggressive impulses but can't express them appropriately; usually overcontrolled, but occasional brief episodes of assaultive, violent acting-out; lacks insight into origins and consequences of behavior; extrapunitive; does not see own behavior as problematic
- o If scale 4 is higher than scale 3 (at least 5 T-score points), problems with uncontrolled anger expression are more likely; if scale 3 is higher than scale 4 (at least 5 T-score points), uncontrolled anger expression is less likely
- o Free of disabling anxiety and depression; somatic complaints may occur; occasional upset does not seem to be related directly to external stress
- o Deep, chronic feelings of hostility toward family members; demands attention and approval from others; sensitive to rejection; hostile when criticized; outwardly conforming but inwardly rebellious; sexual maladjustment and promiscuity common; suicidal thoughts and attempts may follow acting-out episodes; most common diagnoses are passive-aggressive personality and emotionally unstable personality

Individuals with a 3-4 high point pair have been found to display different behaviors than individuals with a 4-3 high point pair. The relationship between Scale 3 and Scale 4 serves as an index of whether clients will overtly express or inhibit their socially unacceptable impulses—particularly anger, aggression, and hostility. If Scale 3 is higher than Scale 4, then a rather passive-aggressive expression of anger is likely. When aggressive actions do occur, individuals with this high point pair deny hostile intent and show a striking lack of insight. If Scale 4 is higher than Scale 3, clients are likely to appear overcontrolled and bottle up their anger for long periods of time. They then explode in a rage, periodically committing violent behaviors.

This high point pair reflects clients experiencing a chronic and stable character disorder and tending to be extropunitive in their reactions to stress and frustration. Individuals with this high point pair handle conflicts by using provocation, manipulation, as well as blame, projection, and attempts at domination. Some of these individuals are free of disabling anxiety and depression, but somatic complaints may occur. Individuals with this high point pair typically experience marital disharmony, sexual maladjustment, and alcoholism. Interpersonal relationships usually are tenuous, though many establish enduring, though turbulent, relationships with marginal, acting-out individuals, thereby vicariously gratifying their own antisocial tendencies. Psychotherapeutic intervention proves difficult because such clients are apt to use psychotherapy for voicing complaints about others instead of concentrating on their own problems. Their motivation for help is typically weak and of questionable sincerity. Personality disorder diagnoses are most commonly associated with this high point pair.

Definition: *3-4* is associated with greater intropunitiveness, discomfort, fatigue, immaturity, inhibition, passivity, and somatic complaints and concerns. By contrast, *4-3* is associated with greater mistrust, extropunitiveness, irritability, and resentment. Both reflect personal and social comfort and skill.

- o Emotional instability, immaturity, egocentricity, and irresponsibility, with chronic problems in the control and expression of anger, and substance abuse. Moodiness and temper outbursts. Fragile and brittle emotional and behavioral controls. Temper may erupt in dangerous explosions; may be assaultive/combative when intoxicated. Health concerns and somatic complaints are common. Outwardly conforming but inwardly rebellious. Acts out conflicts but seeks to stay within the law. Disidentified with authority but tries to adhere to convention for the sake of appearances.

Tends to pander to what others will approve. Prefers to express rebelliousness and hostility indirectly through covert and vicarious means. Chronically conflicted about dependency and self-control. Manipulative, seductive, dramatic, and controlling in interactions, but fearful of rejection. Socially smooth and poised; comfortable playing approved social roles. Seeks attention and approval, tending to become suddenly frustrated, irritable, or hostile when these are withheld. Strongly denying of anger, cynicism, hostility, mistrust, and resentment. Paranoid features not uncommon. Look for sexual promiscuity and substance abuse, a history of minor delinquencies and adult legal difficulties, instability in employment, marital conflict, fighting or assaults, and suicide attempts. Check *O-H*.

Symptoms and Behaviors

Persons having peaks on Scales 3 and 4 are immature and self-centered, with a high level of anger that they have difficulty expressing. Thus, their anger will often be expressed in an indirect, passive-aggressive style. Outwardly, such individuals are continually trying to conform and please other people, but they still experience a considerable

degree of anger and need to find ways of controlling or discharging it. This anger stems from a sense of alienation and rejection by family members. They might at times vicariously act out their aggression by developing a relationship with an individual who directly and spontaneously expresses his or her hostility. Such a relationship might be characterized by the 34/43 individual's covertly encouraging and fueling the other person's angry expressions, yet on a more superficial social level, disapproving of the other person. Typically, these individuals will have poor insight regarding their own behavior.

If Scale 6 is also high, their lack of insight will be even more pronounced because their hostility will be projected onto others. Usually, past interpersonal relationships have been difficult. There may be a history of acting out, marital discord, and alcohol abuse (check the MAC-R, AAS/Addiction Acknowledgment Scale, APS/Addiction Potential Scale, and MDS/Marital Distress scales). Females are more likely than males to have vague physical complaints such as headaches, blackouts, and upper-gastrointestinal complaints. Despite such complaints, these females are generally free from extensive levels of anxiety. Furthermore, their relationships will be superficial and will be characterized by naive expectations and a perfectionistic view of the world, which they maintain by glossing over and denying conflicts.

The 34/43 code most clearly fits the pattern of a passive-aggressive interactional style. However, histrionic or borderline personalities are also common. Persons with 34/43 code types are also frequently diagnosed as having an adjustment disorder with depressed mood or mixed emotional features. If both scales are extremely elevated (T greater than 85), there may be fugue states in which aggressive and/or sexual impulses will be acted out.

Personality and Interpersonal Characteristics

Conflicts relating to dependence versus independence are significant as both of these needs are intense. These individuals tend to demand approval and affection from others. However, they will also have underlying feelings of anger that can easily become activated by criticism. Superficially, they might appear conforming but underneath they have strong feelings of rebelliousness.

34/43

The most salient characteristic of 34/43 persons is chronic, intense anger. They harbor hostile and aggressive impulses, but they are unable to express

their negative feelings appropriately. If scale 3 is higher than scale 4, passive, indirect expression of anger is likely. Persons with scale 4 higher than scale 3

appear to be overcontrolled most of the time, but brief episodes of aggressive acting out may occur. Prisoners with the 4-3 code type have histories of assaultive, violent crimes. In some rare instances, individuals with the 34/43

code type successfully dissociate themselves from their aggressive acting-out behavior. 34/43 individuals lack insight into the origins and consequences of their behavior. They tend to be extrapunitive and to blame other people for their difficulties. Other people may define the 34/43 person's behavior as problematic, but he or she is not likely to view it in the same way.

Persons with the 34/43 code type are reasonably free of disabling anxiety and depression, but complaints of headaches, upper gastrointestinal discomfort, and other somatic distress may occur. Although these persons may feel upset at times, the upset does not seem to be related directly to external stress.

Most of the 34/43 person's difficulties stem from deep, chronic feelings of hostility toward family members. They demand attention and approval from others. They are very sensitive to rejection, and they become hostile when criticized. Although they appear outwardly to be socially conforming, inwardly they are quite rebellious. They may be sexually maladjusted, and marital instability and sexual promiscuity are common. Suicidal thoughts and attempts are characteristic of 34/43 individuals; these are most likely to follow episodes of excessive drinking and acting-out behavior. Personality disorder diagnoses are most commonly associated with the 34/43 code type, with passive-aggressive personality being most common.

34's

Enough college women appeared in Black's group with 34 patterns to provide him with a basis for analyzing this code group separately. The peers of these college girls described them only as impatient. They did not apply the terms conventional, dependent, peaceable, and relaxed. In their selfdescriptions the 34 women described themselves as energetic, frivolous, incoherent, talkative, and reasonable. They significantly avoided applying the terms affectionate, sensitive, shy, irritable, or dreamy, and did not say they had aesthetic interests. The role of scale 4 can be seen here as it works in changing the social stimulus value of the 34 women. In this profile, where scale 4 is prominently elevated but exceeded by the level of scale 3, Welsh and Sullivan (1952b) noted a preponderance of passive-aggressive, passive type, problems among patients in a sample of Veterans Administration psychiatric cases. The magnitude of scale 4 seems to reflect the aggressive or hostile feelings and impulses that are present to a significant degree, while the scale 3 height in turn shows that repressive and suppressive controls are even stronger than the impulse. Consequently the aggressions these persons would otherwise be expected to show intensely are kept from direct expression, appearing only obliquely, ineffectually, or sporadically. When aggressive actions toward others do appear, these persons often deny hostile intent, showing lack of insight into either the origins or the manifestations of their behavior. Renaud's (1950) data indicate that the combination of these two scales also bears a direct relationship to the manifestation and personal acceptance of homoerotic sexual feelings stemming from personality inversion. Men who had elevated scores on scale 5 (Mf) and whose scores on scale 3 were higher

than their scale 4 scores showed fears of being homosexual but generally were less likely to have acted upon their sexual impulses than men with similar scale 5 values but with the heights of scales 3 and 4 reversed. The latter group had typically formed a number of extended homosexual liaisons and rather freely acknowledged homoerotic preferences and practices. Thus, scale 3 in its relationship to scale 4 appears to serve as a measure of control and inhibition of socially unacceptable impulses. Guthrie's observations of the 34 group were also consistent with those above in that problems of impulse control appeared. He found the presenting complaints among these patients to be largely centered on the upper gastrointestinal tract and of a variety neither acute nor very incapacitating. They were unable to recognize their own limitations. They seemed particularly to be sexually maladjusted. Marital difficulties were numerous and divorces appeared more frequently in this code group than was typical in the population under study. The women did not show in their histories markedly psychopathic features but appeared to be overly controlled and rather perfectionistic in their self-attitudes. Consistent with this picture of control and guardedness is the fact that treatment had relatively little effect on these patients.

(Dahlstrom, Welsh, & Dahlstrom, 1979)

3-4 See also the 4-3 combination, p. 148.

1. Scale 4 shows the amount of aggressive or hostile feelings the person has, while scale 3 indicates the controls the person has available (Dahlstrom et al., 1972). In this 3-4 pattern, since scale 3 is higher than scale 4, the aggressions and hostilities shown by the 4 scale would tend to be masked and only shown indirectly, most likely passive-aggressively, because of the denial and controls shown by the higher 3 scale.
2. These people tend to be very immature. They may satisfy their own aggressions and hostilities in an indirect manner by having friends who are acting out (Carson, 1969).
3. In a VA hospital, men with this combination tended to have many socially unacceptable impulses with a fairly effective inhibitory or suppressive control. They tended to be passive aggressive (Hovey & Lewis, 1967).
4. Adolescents in treatment (Marks et al., 1974) with the 3-4/4-3 pattern were referred for sleep difficulties and sometimes suicidal thoughts. They tended to resent their sisters. The majority were heavy drug users and one third had made suicide attempts. The Marks, Seeman, and Haller book should be consulted for further information concerning this pattern.

5. Internal medicine patients with this profile code and the 3-6 code tend to show some of the same behavior. They typically are women who have a superficial outlook on life and an inability to recognize the shortcomings of either themselves or their friends. In spite of this, the interpersonal relations of these women are tenuous and many experience well-rationalized hostility toward their immediate family (Guthrie, 1952).
6. Kelley and King (1979a) found only female clients in a college counseling center with a 3-4/43 profile. They were coming in to therapy for marital problems, particularly sexual difficulties. They were excitable and complained of hostile feelings and aggressive outbursts. They also have many physical complaints. These women tended to overcontrol their anger and express it in irrational outbursts of rage.

Description:

Chronic anger/hostility, impulse control problems, violent outbursts (may be normally overcontrolled), sensitive to criticism, use projection and denial, passive-aggressive, conflicts around dependency, avoid responsibility, masked depressive component

Possible Diagnoses:

Histrionic, Borderline, Passive-aggressive, avoidant, Dissociative, Intermittent explosive, Manic, Pedophilia, Psychogenic amnesia, Voyeurism, Substance abuse, Rape

Modifying Scales

- o When Scales Correction (K) and Lie (L) are elevated, clients will display even more overcontrol, denial, and conformity, and the episodic acting out associated with the Scale 4 will be more covered over but potentially more extreme because it comes as a collapse of overcontrol. These individuals may show conformity to societal rules but then may associate with friends who are rebellious or acting out.
- o When Scale 1 Health Concerns (HEA) or Somatic Complaints (RCI) are elevated, look for more physical complaints associated with the overcontrol, with a tendency to use physical symptoms as a way of manipulating others.
- o When Scale 2 is coded third, clients may complain of sadness or dysphoria but will tend to exhibit irritability, sullenness, and angry depression.

- o When Scale 7 is elevated, look for anxiety around expressions of anger or rejection of others. There will be more role playing and need for others' approval, and any sexual, antisocial, or interpersonal acting out will be followed by apprehension, anxiety, and guilt.
- o When Scale 6 is elevated, clients will show a tendency to build rationalized resentments, especially if Poignancy (Pa2) and Naïveté (Pa3) are elevated. They will be conforming and socially appropriate but will have the potential to emotionally explode into a rationalized outburst.
- o When Scale 9 is elevated, these individuals can be quite charming, playing the right role, but then showing explosive outbursts followed by charming niceness. They are driven to succeed, need a great deal of approval, and can be quite promiscuous, seductive, and unflappable.
- o When Over-Controlled Hostility (OH) is elevated, these clients may go for long periods showing little overt anger, but as control breaks down they can become verbally and even physically assaultive.
- o Often, Inhibition of Aggression (Hy5) is elevated, reflecting their sensory inhibitions around any aggression or violence and their discomfort with conflict and confrontation.
- o Antisocial Practices (ASP) or Antisocial Behavior (RC4) elevations would predict acting out with effective role playing to avoid discovery. Any elevation on Fears (FRS) would be associated with the symbolic manifestation of their internal mixed feelings and fears of loss of emotional control. Fear of flying, bridges, high places, and open spaces are symbolic manifestations of their fear of loss of control over their impulses.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Male

Low 0 Father conflict, one interview only, aggressive or belligerent, wants answers or insists on test scores. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, lack of social skills, mother conflict, being nonresponsive or nonverbal, being nonverbal or a nonrelator, being unrealistic or illogical, nervousness, restlessness, unhappiness.

Female

Low 0 Lacks academic drive, marriage oriented, tense on examinations, home conflict, socially extroverted.

- Note: Scale coded low was infrequently associated with home conflict.

Low 1 Lacks academic drive, home conflict, socially extroverted.

Low 2 Lacks academic drive, home conflict, socially extroverted.

- Note: Scale 2 coded low was infrequently associated with home conflict.

Low 5 Lacks academic drive, distractible in study, home conflict, rebellious toward home, lacks skills with the opposite sex, headaches, insomnia, exhaustion, anxieties, indecisive.

Low 6 Lacks academic drive, vague goals, home conflict.

Low 7/8/9 Lacks academic drive, home conflict.

Nothing Low Lacks academic drive, home conflict, father conflict, mother conflict, verbal, tense on examinations.

(Drake & Oetting, 1959)

o **Check:** *ANX, DEPI, DEP2, HEA3, ANG1* (low), *ANG2* (low), *CYN1* (low), *CYN2* (low), *ASPI* (low), *ASP2, TPA1* (low), *TPA2* (low), *SOD1* (low), *SOD2* (low), *FAM1, FAM2, AGGR* (low), *DISC* (low), *Dr1, Dr3, Dr4, Hy1, Hy2, Hy3, Hy4, Hy5, Pd1, Pd2, Pd3, Pd4, Pd5, Si1* (low), *Si2* (low), *A, R, O-H, MAC-R, APS, AAS, MDS*.

TREATMENT

Childhood histories for these individuals are associated with early rejection or being discounted by a controlling and arbitrary caregiver. In some cases, abuse precipitated the adaptive response of attempting to placate by role-playing, manipulating, and denying the emotional pain associated with the abuse. From an early age, these individuals may have learned to be survivors, subtly manipulating others and telling white lies to get their needs met. In other cases, caregivers encouraged their children to act out, perhaps in response to an overcontrolling spouse. The profile suggests a shutting down of emotional spontaneity in order to fit in and avoid rejection from an explosive and rejecting caregiver. These individuals can actually rehearse what role they want to play in a given social situation. Consequently, they often excel in sales and other people-related jobs where their ability to fit in with diverse people is rewarded. In treatment, they are sensitive to disapproval or any suggestions that they are mentally ill. Watch for what the patient denies, as this is often the source of their conflict. The 34/43 will tend to role-play for the therapist, so in order for insight to develop, it is important to discuss the therapeutic relationship. These individuals need much approval from the therapist in order to become less defensive. Insight therapy and exploring early childhood experiences of disapproval would help in developing awareness about their tendency to role-play. Define them as people who have intense mixed feelings. On the one hand, they want to please others and, at the same time, they resent being controlled. Help them to see how this stems from a childhood in which they wanted their parents' approval and yet feared unpredictable rejection; that they had to role-play and manipulate in order to get their needs met. Help them determine how they can ask for what they want without being angry or manipulative. Giving them an exercise to express their feelings for a specific period of time, such as a day, directly and without manipulation, could help reduce over-control. If the patients feel criticized by the therapist, they will likely terminate therapy.

Treatment: Rule out psychotic disorder, especially defensive paranoid schizophrenia. Non-introspective, with denial and lack of insight. May benefit from assertiveness training or treatment of substance abuse, but course tends to be chronic.

- Frequent diagnoses: passive-aggressive interactional style, histrionic or borderline personalities, adjustment disorder with depressed mood (or mixed emotional features), fugue states in which aggressive and/or sexual impulses will be acted out (if both 3 and 4 are extremely elevated; T greater than 85).
(Groth-Marnat, 2009)

Treatment Implications

Treatment sessions are likely to be stormy because these clients will treat the therapeutic relationship similar to other relationships. Central issues will be self-control and difficulty with taking responsibility for their behaviors. The major resistance to therapy will be that they project blame onto others and have low levels of insight regarding this coping style. Often, they terminate therapy out of anger and frustration. Sometimes internal motivation to seek therapy is lacking, and they have been forced into treatment through external pressures from their spouses, work, or the legal justice system. Because they are relatively more responsive to peer (versus authority) pressures, group therapy can be quite effective. It is often useful to arrange for some external monitoring and external motivation to keep them in treatment.

Therapy and Therapeutic Pitfalls

Clients with this profile tend to selectively report, partly because of their ability to deny and partly because they play the right role to avoid criticism and rejection. Family or marital therapy can be useful, as these provide extra data points for the therapist. These individuals are quite charming and likeable, and they lack insight about their vulnerabilities. They are concerned about the therapist's view of them and so tend to view and report their lives through rose-colored glasses. Often, they will actively deny negative emotions, which is a clue that they are actually experiencing them. When clients say, "I'm not angry with Person A...", the therapist could respond, "Yes, you're not particularly angry with Person A, but you are somewhat frustrated." This allows them to engage repressed resentments without feeling confronted. Dealing with the transference and the clients' concerns that the therapist is critical, rejecting of them, or perhaps playing an effective role is an important early component of psychotherapy. They tend to have difficulty engaging deep, non-defended emotions and vulnerabilities. Help the clients understand that their mixed feelings toward loved ones are understandable. Give them feedback about how they are pleasers and conformers but also have a rebellious and independent side in order to validate them and allow them to begin exploring their nonconformist, angry, and self-indulgent side. Once clients become more comfortable accepting

mixed and ambivalent feelings, explore the details of childhood moments of feeling rejected and discounted by an abusive and even explosive parent. Talk about any memories of consciously employing the switching off of feelings and becoming numb to avoid feeling the pain. Discuss how their defenses developed in an attempt to please and placate authority figures while maintaining a self-protecting distance from emotional closeness. These clients generally accept an interpretation that they have two sides to them: a conformist or pleaser side and a more adventurous and even rebellious side. Help them understand how they tend to give others mixed messages, reflecting these ambivalent dynamics. In relationships, when they feel rejected, they are quick to threaten to leave or even to divorce, reflecting an internal panic about dealing with any new rejections that may stimulate their past rejection scar tissue. In brief psychotherapy, help them realize that they need to develop effective ways to deal with both sides of their personalities and to avoid selective reporting and role playing. Teach them assertive skills so that they can ask for what they want rather than to instinctively please others and then manipulate them to get out of their commitments.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Treatment and Self-Help Suggestions

1. Explore with your therapist any memories you had as a child where you felt particularly rejected and discounted by a parent figure. Try to capture what it felt like as a small child dealing with an angry parent. Can you recall the feeling of numbing yourself, almost getting out of your own skin as if you were observing the situation from a distance? See if you can develop some empathy for yourself as a child, feeling overwhelmed and rejected. Try to get in touch with the anger you might have felt and, with the help of your therapist, role play standing up for yourself. Fearing criticism and the accompanying feelings of rejection, explore how you learned to play the right role to avoid it.
2. Work with your therapist to discover who you are and what you want versus your instinct to fit in, to play the right role, and to please others. Examine any irrational beliefs that may be at the root of your desire to please others. Such irrational beliefs are often signaled by words such as *should*, *must*, or *have to*. For example, “I should always be pleasant,” or “Everyone must like me.” Ask yourself (1) Where is the proof that this belief is true? (2) Is my irrational belief helping me or making things worse? And (3) Is this belief logical and does it make common sense?¹
3. Practice saying “no” to people when they make requests of you rather than being automatically agreeable and then finding ways to avoid fulfilling your commitment. Learn skills to help you break your habit of

saying yes (e.g., buy time by asking to “think about it,” identify your options, select the best one, and respond with a firm no or a counterproposal).²

4. Whenever you notice that you are being sarcastic or joking angrily, identify whether you are feeling anger that you’re unaware of. Learn to recognize some of the subtle signs of anger (e.g., tight muscles, clenched fists, frowning, negative thoughts). Train yourself to talk about your angry feelings, and assertively discuss with others what is frustrating you. Don’t allow resentments to build because a small trigger can then cause you to get quite angry and destructive. *Controlling Anger Before It Controls You* is an excellent online brochure from the American Psychological Association (www.apa.org/topics/anger/control).
5. Discuss with your therapist your use of chemical agents and alcohol. Explore whether you’re using substances as a way of relieving stress and tension.
6. If you experience any physical symptoms of stress such as headaches, low back pain, or stomach upsets, use these as a barometer of your level of stress and tension. When your physical symptoms increase in intensity, take time to think about whether you might be angry or frustrated about something and are avoiding dealing with it. Learn assertiveness techniques to help you express your feelings openly and directly in a way that is respectful of others. *When I Say No, I Feel Guilty* by Manuel Smith (1975) can be used to learn more about assertiveness skills.
7. In close relationships, become aware of how cautious you are feeling that you’re going to be rejected or hurt. In intimate moments, watch your tendency to withdraw, to get numb as if protecting yourself from too much closeness out of fear of rejection. Learn to ask for what you want, and be truthful without fearing that it will lead to being rejected by others.
8. Resilience building: Building and practicing your signature strengths can help increase your well-being and may reduce your sensitivity to rejection. The Web site www.authentichappiness.com has a questionnaire that will help you determine your “signature strengths.” Write about novel ways to use your signature strengths every day for a week.³

¹ Rational-emotive therapy (RET) is a treatment that can guide people to see how their beliefs are needlessly disturbing to them; to work at defeating emotional, cognitive, and behavioral problems that result from irrational thinking; and ultimately to achieve self-fulfillment and self-actualization. An excellent summary of the current state of RET can be found in the *Journal of Consulting and Clinical Psychology* in an article titled “Reflections on Rational-Emotive Therapy” (Ellis, 1993).

² An excellent book to use with your client is *The Disease to Please: Curing the People-Pleasing Syndrome* (Braiker, 2001).

³ A review of interventions from the field of positive psychology found that using signature strengths in a new and different way each day for 1 week increased happiness and decreased depressive symptoms for 6 months (Seligman, Steen, Park, & Peterson, 2005).
(Levak, Siegel, Nichols, & Stolberg, 2011)

THERAPEUTIC FEEDBACK LANGUAGE

Your profile shows that you have two personality traits, which at times can feel contradictory. On the one hand, you are a people pleaser and conflict avoider. It is important for you to get along with others and to fit in and play the right social role. It is upsetting to you if people are critical or judgmental of you, and you have become skilled at “reading” what people expect of you. At the same time, you dislike being controlled and value your independence. Wanting to please and wanting to avoid making waves sometimes can be at odds with wanting to do your own thing and be free of others’ control. In some cases, people with your profile have learned to play different roles according to who they are with. At times you might even find yourself rehearsing what kind of role you want to play in different social situations. At other times, you manipulate people by telling white lies or selectively reporting in order to not make waves but still get what you need. People with your profile often grew up in environments where a caretaker was emotionally explosive and, when angered, was rejecting. Early episodic angry rejections were likely quite painful for you. You learned that you had to “read” your caretakers and anticipate their moves to avoid rejection or, in some cases, even physical abuse. Learning to avoid rejection, you likely had to learn how to couch and color the truth in order to avoid their anger. Consequently, you may now be going through life playing roles and telling white lies. You may not have learned how to express your frustration and anger in a direct and honest way. Occasionally, your anger may erupt and you may express it loudly and impulsively, without realizing that tension had been building up inside of you. Work with your therapist at identifying situations from your childhood where you felt a caretaker’s anger as rejecting and discounting. Explore what that felt like so that you can understand how you learned to avoid anger by playing a role. With your therapist, commit to spending a day where you keep a diary of how you are feeling, paying particular attention to feelings of anger or frustration. When you have a request of someone, rehearse with your therapist how you can ask for what you want without feeling the need to manipulate or selectively report in order to get it. Role-play with your therapist expressing anger directly. Identify with your therapist behaviors you feel reflect who you really are versus behaviors that you feel you have to role-play.

Feedback Statements—Elevated Profiles (T-Score > 65)

Relationship Difficulties

People with your profile often seek treatment because they are experiencing some kind of relationship difficulty. You may be feeling somewhat trapped and hemmed in or perhaps rejected and discounted by someone you feel close to. You are an interesting and complex person because you tend to have mixed and sometimes contradictory emotions. You want closeness, intimacy, and warmth, but at the same time, you value independence and dislike being controlled. Getting those two pieces of you aligned in a relationship can be difficult. You can experience loneliness and unhappiness because few people really ever know all the different sides of you.

Anger Problems

People with your profile dislike conflict and tend to work hard to avoid it. It's not that you hate all conflict, and you're not afraid to confront people if you have to; however, you generally try to avoid it. Anger and resentment can become stored up as you try to avoid it until it wells up in an angry, explosive outburst. In some cases, people with your profile don't express anger for long periods of time but, in other cases, they express it episodically when some minor frustration is the straw that breaks the camel's back. Along the way you may communicate annoyance in subtle ways, perhaps through sarcasm or an edgy bantering humor.

Role Playing or Conflict Avoiding

Your profile suggests that you are good at using your perceptiveness to play the correct social role. It's as if you watch yourself, standing back and observing yourself as you go through life, sometimes choosing the kind of role you're going to play depending on the people you're around at the time. Your role playing and telling white lies is a way of avoiding conflict and confrontation. In your heart, you may feel that you are trying to protect others, but on deeper reflection you may find that, in fact, you are protecting yourself against people being angry and rejecting of you since this was so painful growing up.

Somatic Symptoms

You may experience some physical symptoms of stress. Headaches, stomach upsets, low back pain, and even occasional sexual difficulties may reflect the fact that you tend to hold in stress and tension until it begins to affect your body.

Alcohol or Substance Abuse

Because you tend to experience mixed emotions, you often feel more stress and tension than you would like. You are a pleaser, a conformist, and a conflict avoider. At the same time, you are independent, adventurous, and excitement seeking, and you hate to be controlled. These two complex emotions

are, at times, contradictory. This may put a lot of stress on you so that you may find yourself occasionally using alcohol or chemical agents as a way of letting go and freeing yourself to experience the side of you that you keep under wraps and hold in check most of the time. When you do drink or use chemical agents, you may end up acting in impulsive ways that cause you trouble.

Acting Out

If you use drugs or alcohol, or even if you don't, you may episodically act out. You may use drugs and alcohol as a way to "loosen up." Feeling trapped and hemmed in because you try to please and do what is expected of you, you may eventually do something impulsive as a way of feeling free and alive.

Approval Seeking or Conforming

One side of you is strongly approval seeking and conforming. You work hard to fit in and play the right role and to not disappoint people. You might value etiquette and doing things "the right way" to avoid other people's criticism and disapproval.

Rebellious or Hate to Be Controlled

There is another side of you, however, that is quite rebellious and hates to be controlled. These two sides of you will alternate. A lot of the time, you will fit in and play the right role, seeking to avoid people's rejection and criticism. From time to time, however, you'll find yourself feeling hemmed in and trapped, and then, either after drinking, using drugs, or maybe even without apparent provocation, you will find yourself doing something impulsive and even rebellious. When this side of you emerges, you may attempt to conceal your actions by telling white lies or manipulating people's perceptions to avoid their discovering this part of you. In some cases, people with this profile lead double lives to try to meet the needs of their two psychological sides. It's going to be important for you to find a way to combine these two sides of yours in a way that isn't destructive. Sometimes people with this personality find an outlet through having eccentric, unusual, even rebellious friends.

Doesn't Trust

Even though you play the right role and want to get along with people and come across as accommodating, there is a part of you that has difficulty trusting emotionally and letting down your guard so people can get close to you. Sometimes you spend time thinking about how you're supposed to behave to avoid others rejecting you. It's hard for you to let people know how you feel in some situations, to be vulnerable, and to allow others to see your vulnerable feelings.

Sensitive to Rejection

Growing up, one of your parents may have been unpredictably explosive or somehow discounting or rejecting of you. That was particularly painful, so you learned to play the right role to fit in to parental expectations to avoid anger and rejection. If others are critical of you, it is particularly painful and can make you angry because it stimulates the scar tissue of your early unpredictable childhood rejections. No one likes to be criticized, but for you criticism can sometimes feel like rejection. Because of this, it can be hard for you to say or to do anything that can make others feel rejected.

Dissociative

Most people like to forget painful and unpleasant events and to avoid thinking about them. You are particularly good at blocking out awareness of the parts of reality that you don't want to deal with, perhaps after you've done something that might be upsetting. You may have become quite good at dissociating from negative experiences so that you may have memory lapses and periods of your life that you don't recall well. This is a process of protecting yourself against painful memories.

Lifestyle and Background Feedback

People with this profile grew up with parents that could be explosive, even rejecting, and abusive. At the same time the parents could occasionally be loving and supportive. This type of rejection was hurtful to you, so you might have tried to block out the pain and see the best in your parents. They may have taught you to play the correct social role because obtaining others' approval was important to them. Trying to please them and avoid their rejection may have led you to deny parts of yourself by playing the role they demanded of you.

Normal-Range Feedback (T-score 50 to 65)

Your profile is in the normal range. However, it does show that you are mildly sensitive to rejections and being discounted by others, so that you may project the same sensitivities onto them. It is somewhat hard for you to say no to people or to confront them. At times you may find yourself putting the most favorable light on an issue to protect people's feelings and to protect yourself from being rejected in return. Although you are sensitive to society's norms and values, you are also mildly nonconformist and enjoy a diverse group of friends, some of whom are conformists and some are not. People with your profile are usually good at working with others and do well in sales or management jobs. You seem to have a knack for understanding other people's feelings and for wanting to please them. Sometimes your approach may lead you to feel somewhat isolated since few people get to know you in all your

different roles. Being a sensitive person and not wanting to hurt other people's feelings, you may at times sweep your anger "under the carpet," leading to you getting angry infrequently but more intensely when you do get angry. (Levak, Siegel, Nichols, & Stolberg, 2011)

345/435/534 Codes

(see also 34/43 and Scale 5 Codes)

In males, the addition of Scale 5 predicts passivity and sensitivity to rejection, with a consequent increase in the sexual difficulties that individuals with 34/43 codetypes already exhibit. Men with this profile crave approval, fear rejection, and are afraid of being trapped. They experience approach avoidance in their intimate relationships. The Scale 4 elevation suggests manipulation in the service of the drive of Scales 3 and 5 for approval and fear of rejection. The result is a charming, seductive, and role-playing individual who constantly elicits love and approval and avoids rejection by selectively reporting.

The 345/435 male often seeks sexual experiences that reflect his fear of rejection and his need for nonconformist excitement. Some have engaged in exhibitionism, voyeurism, or sadomasochism. Others have homosexual fantasies or may be bisexual.

- These men are typically immature and sexually inadequate. Exhibitionism, voyeurism, and a need for more than usual sexual stimulation is possible (Lachar, 1974).

Women with this combination are assertive, highly sexual, and manipulate others with their seductive sexuality.

Male

Low 0 Father conflict, home dependency, one interview only (3-0), four or more conferences (35), aggressive or belligerent, wants answers or insists on test scores.

- Note: Scale 5 coded high was infrequently associated with wanting answers or insisting on test scores. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, lack of social skills, lack of skills with the opposite sex, mother conflict, being nonresponsive or nonverbal, being nonverbal or a nonrelator, being unrealistic or illogical, nervousness, tension, restlessness, unhappiness.

Low 1 Home conflict, home dependency, four or more conferences, restless.

- Note: Scale 3 coded high was infrequently associated with restlessness.

Low 2/6/7/8/9 Home dependency, four or more conferences.

Nothing Low Lacks skills with the opposite sex, home conflict, home dependency, four or more conferences, insomnia.

- Note: Scale 4 coded high was infrequently associated with lack of skills with the opposite sex.

Female

Low 0 Home conflict, socially extroverted, marriage oriented, lacks academic drive, tense on examinations.

- Note: Scale coded low was infrequently associated with home conflict.

Low 1/2 Home conflict, socially extroverted, lacks academic drive.

Low 6 Home conflict, vague goals, lacks academic drive.

Low 7/8/9 Home conflict, lacks academic drive.

Nothing Low Home conflict, father conflict, mother conflict, verbal, lacks academic drive, tense on examinations, distractible in study.

(Drake & Oetting, 1959)

TREATMENT

34/43 individuals fear rejection, crave approval yet dislike feeling controlled. The addition of Scale 5 for men suggests an increase in fears of rejection. Elevations of Scale 5 in females suggest an aggressive sexuality with a willingness for sexual experimentation that men often find irresistible. These women are often perceptive and use their social skills to obtain others' approval and dependency on them, which satisfies their need for approval, but elicits their fear of being controlled. Treatment should concentrate on helping these individuals deal with early caregiver rejection. Explore any specific memories when they felt startled by an abrupt, explosive parent who could otherwise be loving. Their adaptive response was to role-play and placate the rejecting parent, denying the emotional impact of the rejection and "seducing" the parent into providing love and approval by being manipulatively charming. Help them see how this adaptive response has become a lifestyle in which they constantly seduce others into relationships that then burden them. Men often had intense loving and rejecting relationships with female caretakers and women with male caretakers.

THERAPEUTIC FEEDBACK LANGUAGE

For men: Your profile suggests you are a creative, sensitive and perceptive individual who is concerned with rejection and disapproval. You have learned to avoid rejection by playing the right role. People with your profile are often good at sales because of their ability to "read" others' needs. At the same time, you fear being controlled or trapped. You may find yourself selectively reporting or lying to others to avoid them feeling rejected and, therefore, rejecting you. Your mixed feelings of wanting approval but fearing being trapped may be reflected in your sexuality.

You may seek sexual experiences that allow you to feel excitement but minimize the fears of rejection. Explore with your therapist times in your childhood when you felt rejected or discounted by an opposite sex parent. Explore how this may have led to you constantly placating and seducing others, but at the same time, fearing intimacy in case you are rejected or trapped. Avoid selective reporting by telling people how you feel and what you want. If you have fears of rejection, express those directly and learn to say no to people rather than constantly trying to please others by impulsively being agreeable and then later having to manipulate out of commitments.

For women: Your profile suggests that you are comfortable with men as friends and enjoy traditionally masculine activities and interests. You can be assertive and not afraid to use your sexuality to get what you want. You probably find it easy to elicit men's approval and you can readily manipulate them into getting what you want. You have learned to avoid rejection by playing the right role. People with your profile are often good at sales because of their ability to "read" others' needs. At the same time, you fear being controlled or trapped. You may find yourself selectively reporting or lying to others to avoid them feeling rejected and, therefore, rejecting you. Your mixed feelings, wanting approval but fearing being trapped, may be reflected in your sexuality. You may seek sexual experiences that allow you to feel excitement but minimize the fears of rejection. Explore with your therapist times in your childhood when you felt rejected or discounted by an opposite sex parent. Explore how this may have led to you constantly placating and seducing others, but at the same time, fearing intimacy in case you are rejected or trapped. Avoid selective reporting by telling people how you feel and what you want. If you have fears of rejection, express those directly and learn to say no to people rather than constantly trying to please others by impulsively being agreeable and then later having to manipulate out of commitments.

346/436 Codes

The addition of Scale 6 to the 34 codetype reflects the likelihood of an accumulation of rationalized resentments. The 346 individual is socially conforming, yet seductive, often fastidious and with firmly held beliefs about what is proper, right, and correct social behavior. The addition of Scale 6 increases the 34/43 individual's sensitivity to rejection and loss of social approval. They are very sensitive to criticism, yet tend to be quite critical and judgmental of others. They are blame-oriented and often feel justified in punishing others for hurting or disappointing them. Built-up anger is expressed as an explosive, highly rationalized outburst of blame and judgment, and they often lack awareness of how their anger affects others. They rarely see shades of grey, justify their position as morally righteous, and are quite unforgiving, which is often reflected in an elevated *Pa3* score. 346 individuals are very conscious of their social role and are often seen as sexually attractive, although they may be offended when others respond to their sexuality. They fear emotional intimacy and lack psychological insight. In intimate relationships, they have

difficulty articulating what they want. Rather, they allow their feelings to be hurt and then express their unfulfilled desires as resentments and demands. Blame tends to be an important part of their interpersonal style, perhaps reflecting their own fears of being blamed or judged. The 346/436 codetype has been associated with unresolved divorce custody cases.

o 3-4-6/3-6-4/4-3-6/4-6-3/6-3-4/6-4-3

o Rigid, rationalizing, resentful, and vindictive. Outwardly conforming but inwardly hostile; hypersensitive to criticism or rejection; unable to compromise; intolerant of any kind of challenge. Possessive. May collect evidence to prove others' bad faith. Look for severe marital conflict; pathological jealousy. See 3-4/4-3; 3-6/6-3; 4-6/6-4. Check *O-H*.

Male

Low 0 Father conflict, one interview only, worries a great deal, aggressive or belligerent, wants answers or insists on test scores.

- Note: Scale coded low was infrequently associated with worrying a great deal. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, lack of social skills, mother conflict, being nonresponsive or nonverbal, being nonverbal or a nonrelator, being unrealistic or illogical, nervousness, restlessness, unhappiness.

Low 1/2/5/7/8/9/Nothing Low Worries a great deal.

Female

Low 0 Home conflict, resistant in the interview, tense on examinations, marriage oriented, lacks academic drive, socially extroverted.

- Note: Scale coded low was infrequently associated with home conflict.

Low 1 Home conflict, lacks academic drive, socially extroverted.

Low 2 Home conflict, lacks academic drive, socially extroverted.

- Note: Scale 2 coded low was infrequently associated with home conflict.

Low 5 Home conflict, rebellious toward home, lacks academic drive, distractible in study, anxieties, exhaustion, insomnia, headaches, lacks skills with the opposite sex, indecisive, physical inferiority.

Low 7/8/9 Home conflict, lacks academic drive.

Nothing Low Home conflict, father conflict, mother conflict, lacks academic drive, tense on examinations, verbal, 8+ conferences, restless.

(Drake & Oetting, 1959)

TREATMENT

Look for childhood conditioning experiences of rejection and being discounted by authoritarian caregivers who were shaming, critical, and blaming. The 346 profile may represent an adaptive response to conditions in which the individual has learned to roleplay, subtly manipulate, and be mindful of “who is to blame” in any given situation, perhaps as a way of avoiding being blamed. Insight therapy, exploring childhood memories of having been discounted, rejected, and criticized, could help them understand the origin of their tendency to repress and deny unacceptable impulses until they feel completely justified. Help them understand that by the time they feel justified in expressing their needs, they are already resentful. Give homework exercises in which they focus on asking for what they want from a loved one before they become resentful and, therefore, demanding. This can help them to see how they use moral judgment as part of their attempts to rationalize that their wants are justified. They give others the subtle message of “You ought to do this for me because this is the right thing for you to do and you owe it to me,” but overtly deny that they are making a demand. By not making requests directly, instead using judgment, they protect themselves from feeling controlled by any sense of obligation. They also voice their opinion as fact, reflecting their fear of being criticized. This has the effect of eliciting others’ resistance, which becomes a self-fulfilling prophecy by creating arguments, which the 346/436 individual anticipates. As they feel criticized or judged, this justifies their protecting themselves by being vigilant.

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you are a sensitive person with very high standards and that you tend to be your own worst critic. It is important for you to be above criticism and judgment, so you try to do what is expected of you. You’ve learned how to play the right role to avoid rejection. It is hard for you to express anger or resentment to others until you feel fully justified in doing so. It is also hard for you to ask people for things directly and you try hard to make sure that when you ask for something you feel justified in doing so. However, your concern about avoiding criticism or judgment, and your desire to be above moral reproach, can mean that sometimes you may not express what you want and what you feel for long periods of time. You may wait until you feel completely justified in expressing your feelings, by which time you are quite resentful and find it hard to forgive. Sometimes people with your profile grew up in environments where parents were extremely critical and where you were forced to conform to very high moral standards. Your parents may have had a tendency to be quite critical and judgmental, and when they were disappointed in your behavior they could be rejecting and shaming. From an early age you likely learned to avoid criticism by fitting in and doing the right thing. No wonder you have a tendency to focus on who’s to blame,

analyzing situations to make sure that you can't be blamed, as if preparing yourself for a constant defense against a parent who is going to be critical and judgmental. Perhaps that is why it is hard for you to ask for what you want directly. You have a tendency to wait until you feel you deserve something, but by then you feel hurt or angry that your needs have not been recognized. People may see your high standards as hard to live up to, and people may see you as someone who is judgmental. Explore with your therapist any childhood events where you felt criticized, judged, and unfairly punished. Explore some of the emotions you may have experienced at that time so that you can identify how you go through life protecting yourself, as if you're about to be criticized or judged. Often when a person anticipates being criticized, they become defensive and ready to protect themselves. This may backfire because others may then become defensive in response, precipitating arguments. Learn to ask for what you want directly before you become resentful. Learn to recognize when your anger is building up so you can express it without blame or judgment.

347 Code

Male

Low 0 Home conflict, father conflict, one interview only, lacks knowledge of information, aggressive or belligerent, wants answers or insists on test scores. This pattern was infrequently associated with lack of social skills, mother conflict, being nonresponsive or nonverbal, being nonverbal or a nonrelator, being unrealistic or illogical, nervousness, restlessness, unhappiness.

Low 1/2/5/6/8/9 Home conflict.

Nothing Low Lacks skills with the opposite sex, home conflict, mother conflict, sibling conflict, nonresponsive or nonverbal, tense, indecisive, unhappy, worries a great deal, insomnia, confused, poor rapport.

- Note: Scale 3 coded high was infrequently associated with mother conflict; Scale 4 coded high was infrequently associated with lack of skills with the opposite sex.

Female

Low 0 Anxieties, insomnia, home conflict, rebellious toward home, tense on examinations, marriage oriented, lacks academic drive, socially extroverted.

- Note: Scale 0 coded low was infrequently associated with home conflict.

Low 1 Anxieties, insomnia, home conflict, rebellious toward home, lacks academic drive, socially extroverted.

Low 2 Anxieties, insomnia, home conflict, rebellious toward home, lacks academic drive, socially extroverted.

- Note: Scale 2 coded low was infrequently associated with home conflict.

Low 5 Anxieties, insomnia, headaches, exhaustion, nervous, home conflict, rebellious toward home, distractible in study, lacks academic drive, lacks skills with the opposite sex, socially insecure, lacks self-confidence, indecisive.

- Note: Scale 4 coded high was infrequently associated with social insecurity.

Low 6 Anxieties, insomnia, home conflict, rebellious toward home, vague goals, lacks academic drive.

Low 8/9 Anxieties, insomnia, home conflict, rebellious toward home, lacks academic drive.

Nothing Low Anxieties, insomnia, headaches, home conflict, rebellious toward home, father conflict, mother conflict, sibling conflict, tense on examinations, lacks academic drive, verbal.

348 Code

Male

Low 0 Father conflict, one interview only, lacks knowledge or information, aggressive or belligerent, wants answers or insists on test scores. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, lack of social skills, mother conflict, being nonresponsive or nonverbal, being nonverbal or a nonrelator, being unrealistic or illogical, nervousness, restlessness, unhappiness.

Low 1/2/5/6/7 Lacks knowledge or information.

Low 9 Introverted or self-conscious or socially insecure, lacks knowledge or information.

Nothing Low Indecisive, unhappy, worries a great deal, insomnia, lacks knowledge or information, confused.

Female

Low 0 Depressed, insomnia, home conflict, overprotective mother, tense on examinations, marriage oriented, lacks academic drive, socially extroverted, verbal.

- Note: Scale coded low was infrequently associated with depression and home conflict.

Low 1 Depressed, insomnia, home conflict, overprotective mother, lacks academic drive, socially extroverted, verbal.

Low 2 Depressed (48), insomnia, home conflict, overprotective mother, lacks academic drive, socially extroverted, verbal.

- Note: Scale 2 coded low was infrequently associated with home conflict.

Low 5 Depressed, insomnia, anxieties, headaches, exhaustion, home conflict, rebellious toward home, overprotective mother, distractible in study, lacks academic drive, lacks skills with the opposite sex, verbal, indecisive.

Low 6 Depressed, insomnia, home conflict, overprotective mother, lacks academic drive, vague goals, verbal,

Low 7/9 Depressed, insomnia, home conflict, overprotective mother, lacks academic drive, verbal.

Nothing Low Depressed, insomnia, headaches, home conflict, overprotective mother, mother conflict, father conflict, sibling conflict, tense on examinations, lacks academic drive, lacks skills with the opposite sex, verbal, 8 + conferences.

349 Code

o 3-4-9/3-9-4/4-3-9/4-9-3/9-3-4/9-4-3

o Better socialized than 4-9/9-4, with strong needs for affection and approval, but with more stimulation seeking, irresponsibility, acting out, and easily threatened autonomy than 3-4/4-3. Look for opportunism, expediency, promiscuity, and substance abuse.

Male

Low 0 Father conflict, one interview only, aggressive or belligerent, wants answers or insists on test scores. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, shyness in the interview, lack of social skills, mother conflict, being nonresponsive or nonverbal, being nonverbal or a nonrelator, being unrealistic or illogical, nervousness, restlessness, indecisiveness, unhappiness.

Low 2 Aggressive or belligerent.

Low 6 Rationalizes a great deal.

Female

Low 0 Home conflict, lacks academic drive, socially extroverted, verbal, marriage oriented, vague goals, tense on examinations.

Low 1 Home conflict, lacks academic drive, marriage oriented, vague goals, socially extroverted, verbal.

Low 2 Home conflict, lacks academic drive, marriage oriented, vague goals, socially extroverted, verbal.

- Note: Scale 2 coded low was infrequently associated with home conflict.

Low 5 Home conflict, rebellious toward home, lacks academic drive, marriage oriented, vague goals, distractible in study, socially extroverted, lacks skills with the opposite sex, verbal, indecisive, anxieties, headaches, insomnia, exhaustion.

Low 6/7/8 Home conflict, lacks academic drive, marriage oriented, vague goals, socially extroverted, verbal.

Nothing Low Home conflict, father conflict, mother conflict, lacks academic drive, marriage oriented, vague goals, tense on examinations, socially extroverted, verbal.

(Drake & Oetting, 1959)

35/53 Codes

There is limited empirical information on this codetype. Men tend to be educated and histrionic and are described as passive, fussy, and culturally, verbally, and aesthetically oriented. They are conflict avoiders and people pleasers. They see themselves as well-adjusted, happy, calm, and self-confident, although others might see them as emotionally demanding. Some can develop physical symptoms in response to stress. They are unlikely to act out in aggressive ways. They have strong needs for attention and affection, and can be somewhat inhibited and over-controlled. Most are intellectual. If Scale 0 is also elevated, they are likely to be shy, anxious, and socially uncomfortable. If the profile is within normal limits or just above the normal range, these men are likely to be seen as peaceable, nurturing, and gentle, although with a tendency toward self-absorption. The 35/53 codetype is also associated with the use of denial and repression as a defense. Though this codetype has been reported as rare in clinical populations, in women it is more common among those applying for reality television roles. These women are competitive and agreeable, with interests that are typically seen as masculine. Scale 4 or 6 is usually the third highest scale in both males and females. Interpretation is best accomplished by initially ignoring the elevated Scale 5, so as to treat the three-point codetype (e.g. 354 codetype) as though it were a two-point code (e.g. 34 codetype). Subsequently, the interpretations of the elevated Scale 5 can be added. If the third highest scale is highly elevated, it should be given particular consideration in interpreting the 35/53 codetype.

o Defensive and grossly lacking in self-awareness. Men may be seen as somatically focused, immature, sociable but superficial, manipulative, and demanding. Women may be verbal, assertive, and irritable, but with low self-esteem and concerns about physical appearance/body image. Check third highest scale.

Male

Low 0 Home dependency, one interview only (3-0), four or more conferences (35), aggressive or belligerent, wants answers or insists on test scores.

- Note: Scale 5 coded high was infrequently associated with wanting answers or insisting on test scores. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, lack of social skills, lack of skills with the opposite sex, mother conflict, being nonresponsive or nonverbal, being nonverbal or a nonrelator, being unrealistic or illogical, nervousness, restlessness, tension, unhappiness.

Low 1 Home dependency, four or more conferences, restless.

- Note: Scale 3 coded high was infrequently associated with restlessness.

Low 2/4/6/7/8/9 Home dependency, four or more conferences.

Nothing Low Home dependency, home conflict, four or more conferences, lacks skills with the opposite sex, insomnia.

Female

Low 0 Lacks academic drive, marriage oriented, vague goals, socially extroverted.

Low 2 Socially extroverted.

Nothing Low Distractible in study, tense on examinations, verbal, mother conflict, father conflict.

(Drake & Oetting, 1959)

Description:

Narcissism, denial, immaturity, passivity

Possible Diagnoses:

Transvestism

TREATMENT

In men, look for a strong early son–mother identification and, for women, a daughter–father identification. The elevation on Scale 3 suggests the adaptive response of repression and denial in response to early childhood experiences of pain. Assertiveness training and insight therapy is useful in recognizing when anger is building.

THERAPEUTIC FEEDBACK LANGUAGE

For men: Your profile suggests that you are a people pleaser and conflict avoider, and that you are a sensitive, culturally and verbally-oriented individual who cares about others' feelings. You enjoy the company of creative, sensitive, non-confrontational people and you care about artistic, creative pursuits and exploring feelings. Sometimes your avoidance of conflict may lead others to see you as somewhat passive. Because you try to stay positive and avoid stressful interpersonal conflicts, your body may occasionally take the strain and you may experience some mild and shifting physical symptoms of stress. Discuss with your therapist how you can learn to recognize when you are angry and learn to express it. You will likely only recognize that you were angry in the past in any given situation rather than be aware of it in real time.

For women: Your profile suggests that you are a people pleaser and conflict avoider, and that you are an active, responsible, practical woman who is comfortable in the world of men. When you're experiencing interpersonal problems you likely want to do something about them rather than spend much time talking about them. You

might not be aware of your own anger because of your concern about staying positive. Consequently, anger may build up inside of you, leading to episodic angry outbursts or perhaps to some vague and shifting physical complaints that reflect inner tension. Learning to recognize when you're angry and learning to express it before it builds up could be a focus of therapy.

354 Code

o Egocentric, passive-aggressive, articulate, and exploitive. Attention seeking. Anxious when not in control of situations. Soft exterior but hard interior. Sexually active but conflicted and insecure.

356 Code

Male

Low 0 Home dependency, one interview only (3-0), four or more conferences (35), aggressive or belligerent, wants answers or insists on test scores.

- Note: Scale 5 coded high was infrequently associated with wanting answers or insisting on test scores. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, lack of social skills, lack of skills with the opposite sex, mother conflict, being nonresponsive or nonverbal, being nonverbal or a nonrelator, being unrealistic or illogical, nervousness, restlessness, tension, unhappiness.

Low 1 Home dependency, four or more conferences, restless.

- Note: Scale 3 coded high was infrequently associated with restlessness.

Low 2/4/7/8/9 Home dependency, four or more conferences.

Nothing Low Home dependency, home conflict, four or more conferences, lacks skills with the opposite sex, insomnia.

Female

Low 0 Lacks academic drive, marriage oriented, tense on examinations, socially extroverted, resistant in the interview.

Low 2 Socially extroverted.

Low 4 Shy in the interview.

Nothing Low Tense on examinations, distractible in study, restless, verbal, 8+ conferences, father conflict, mother conflict.

- Note: Scale 5 coded high was infrequently associated with 8+ conferences, father conflict.

(Drake & Oetting, 1959)

Male

Low 0 Home conflict, home dependency, one interview only (3-0), four or more conferences (35), wants reassurance only, lacks knowledge or information, aggressive or belligerent, wants answers or insists on test scores.

- Note: Scale 5 coded high was infrequently associated with wanting answers or insisting on test scores. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, lack of social skills, lack of skills with the opposite sex, mother conflict, being nonresponsive or nonverbal, being nonverbal or a nonrelator, being unrealistic or illogical, nervousness, restlessness, tension, unhappiness.

Low 1 Home conflict, home dependency, four or more conferences, wants reassurance only, nonresponsive or nonverbal, restless.

- Note: Scale 3 coded high was infrequently associated with restlessness.

Low 2/4/6/8/9 Home conflict, home dependency, four or more conferences, wants reassurance only.

Nothing Low Home conflict, home dependency, mother conflict, sibling conflict, four or more conferences, wants reassurance only, lacks skills with the opposite sex, nonresponsive or nonverbal, tense, indecisive, unhappy, worries a great deal, insomnia, confused.

- Note: Scale 3 coded high was infrequently associated with mother conflict; Scale 5 coded high was infrequently associated with tension.

Female

Low 0 Anxieties, insomnia, lacks academic drive, marriage oriented, tense on examinations, socially extroverted.

- Note: Scale 5 coded high was infrequently associated with anxieties.

Low 1 Anxieties, insomnia.

- Note: Scale 5 coded high was infrequently associated with anxieties.

Low 2 Anxieties, insomnia, socially extroverted.

- Note: Scale 5 coded high was infrequently associated with anxieties.

Low 4/6/8/9 Anxieties, insomnia.

- Note: Scale 5 coded high was infrequently associated with anxieties.

Nothing Low Anxieties, insomnia, headaches, tense on examinations, distractible in study, verbal, father conflict, mother conflict, sibling conflict.

- Note: Scale 5 coded high was infrequently associated with headaches, father conflict, anxieties.

(Drake & Oetting, 1959)

358 Code

Male

Low 0 Home conflict, home dependency, one interview only (3-0), four or more conferences (35), aggressive or belligerent, wants answers or insists on test scores.

- Note: Scale 5 coded high was infrequently associated with wanting answers or insisting on test scores. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, lack of social skills, lack of skills with the opposite sex, mother conflict, being nonresponsive or nonverbal, being nonverbal or a nonrelator, being unrealistic or illogical, nervousness, restlessness, tension, unhappiness.

Low 1 Home conflict, home dependency, four or more conferences, lacks knowledge or information, restless.

- Note: Scale 3 coded high was infrequently associated with restlessness.

Low 2/4/6/7 Home conflict, home dependency, four or more conferences, lacks knowledge or information.

Low 9 Home conflict, home dependency, four or more conferences, lacks knowledge or information, introverted or self-conscious or socially insecure.

Nothing Low Home conflict, home dependency, four or more conferences, lacks knowledge or information, confused, unhappy, worries a great deal, insomnia, lacks skills with the opposite sex, indecisive.

Female

Low 0 Tense on examinations, marriage oriented, lacks academic drive, verbal, socially extroverted.

Low 1 Verbal.

Low 2 Verbal, socially extroverted.

Low 4/6/7/9 Verbal.

Nothing Low Verbal, 8+ conferences, depressed, tense on examinations, distractible in study, lacks skills with the opposite sex, mother conflict, father conflict, sibling conflict.

- Note: Scale 5 coded high was infrequently associated with depression and father conflict.

(Drake & Oetting, 1959)

359 Code

Male

Low 0 Home dependency, one interview only (3-0) , four or more conferences (35), poor rapport, aggressive or belligerent, wants answers or insists on test scores, mother conflict (59).

- Note: Scale coded low was infrequently associated with poor rapport; Scale 5 coded high was infrequently associated with wanting answers or insisting on test scores. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, shyness in the interview, lack of social skills, lack of skills with the opposite sex, mother conflict (3-0), being nonresponsive or nonverbal, being nonverbal or a nonrelator, being unrealistic or illogical, nervousness, restlessness, tension, indecisiveness, unhappiness.

Low 1 Home dependency, mother conflict, four or more conferences, poor rapport, restless.

- Note: Scale 3 coded high was infrequently associated with mother conflict and restlessness.

Low 2/4 Home dependency, mother conflict, four or more conferences, poor rapport.

- Note: Scale 3 coded high was infrequently associated with mother conflict.

Low 6 Home dependency, mother conflict, four or more conferences, poor rapport, rationalizes a great deal.

- Note: Scale 3 coded high was infrequently associated with mother conflict.

Low 7/8 Home dependency, mother conflict, four or more conferences, poor rapport.

- Note: Scale 3 coded high was infrequently associated with mother conflict.

Nothing Low Lacks skills with the opposite sex, home conflict, mother conflict, home dependency, four or more conferences, insomnia, poor rapport.

- Note: Scale 3 coded high was infrequently associated with mother conflict.

Female

Low 0 Socially extroverted, marriage oriented, lacks academic drive, tense on examinations, vague goals, verbal.

Low 1/2 Socially extroverted, marriage oriented, vague goals.

Low 4 Socially extroverted, shy in the interview marriage oriented, vague goals, nonresponsive.

Low 6/7/8 Socially extroverted, marriage oriented, vague goals.

Nothing Low Socially extroverted, marriage oriented, vague goals, tense on examinations, distractible in study, verbal, father conflict, mother conflict.

- Note: Scale 5 coded high was infrequently associated with father conflict.

Code-Type 3-6/6-3

Descriptors

Complaints

Sensitive to criticism, perfectionist, somatic symptoms, anxiety attacks, sexual inhibitions or sexual difficulties

Thoughts

Rational, analytical, fair-minded, approval-seeking sensitivity that can shade to paranoia, self-conscious, injustice collecting, self-righteous, unforgiving, rigid values, naïve

Emotions

Highly sensitive, loyal, easily hurt, prideful, jealous, possessive, unforgiving, difficulty expressing anger, anxiety attacks

Traits and Behaviors

Socially skilled, attractive, fastidious about personal appearance but stiff and formal, “proper,” strives to be above criticism, paranoid traits, conformist, inhibited, self-controlled, conflict avoidant, rigid values, high expectations of others, subtly demanding, naïve

(Levak, Siegel, Nichols, & Stolberg, 2011)

Therapist's Notes

In the normal range the 3-6 code types are poised, controlled, conformist individuals who seek approval and work hard to avoid criticism. It is important to them to be seen as cheerful, polite, and content. Often attractive and fastidious about their personal appearance, they are the Eagle Scouts, cheerleaders, beauty queens, and teacher's pets. At higher elevations this characterization reflects their strong motivation to be seen as nice, proper, well liked, desirable, and above moral reproach, which comes at some cost to their emotional spontaneity and self-awareness. Repressing and denying basic negative human impulses means that they are vulnerable to developing physical symptoms of stress and episodic anxiety attacks that reflect repressed and unintegrated self-centered, sexual, and

aggressive impulses. At times, their sensitivity can shade toward paranoia without overtly psychotic symptoms. Misinterpreting others' motives and feeling unfairly treated and occasionally self-righteous, angry temper outbursts would reflect the subtle paranoid traits associated with this profile. These individuals are highly analytical, rationalizing their emotional responses to others to make sure that they are above reproach. In the process, they can store resentments, which may lead to rare angry outbursts. If they feel slighted, rejected, or criticized, their retaliatory anger will be cloaked in a veneer of socially accepted rationalization. When 3-6 individuals experience someone as "the enemy," they can develop an almost paranoid but usually well rationalized hatred of the individual. The 3-6 is denying, rigid, and inhibited but, at the same time, charming, gracious, and even subtly seductive. Given their need for approval, validation, and acceptance, it makes sense that a meticulous physical appearance and a socially acceptable seductiveness would maximize their chances for getting what they want. However, if others respond to, for example, their seductiveness, they tend to be shocked, as if it suggests that they were inappropriate. Some will complain of occasional acute anxiety attacks, reflecting the eruption into consciousness of poorly integrated, undesirable, and unacceptable emotions. If they feel unfairly treated or threatened, they respond with initial over-control, but eventually they build a case against the perpetrator and become blaming, using various externalizations and justifying their need to retaliate. They have high self-expectations, which they project onto others, and they are quick to be judgmental if they see others as failing to meet their rigid expectations. Religion or other value systems are integrated into their defensive structure as a way of rationalizing their definition of who is "good" and who is "bad." As they are over-controlled and work hard to be socially acceptable, they tend not to express negative emotions or selfish desires directly. These clients have poor awareness that their judgmental attitude aggravates others into argumentative defensiveness. Although the 3-6 code types crave approval and tend to be seductive, they are inhibited sexually. This reflects the general inhibition associated with Scale 3. They desire love and approval, but it's hard for them to let down their guard and express their feelings, perhaps out of fear of being criticized and rejected.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Lifestyle and Family Background

Our hypothesis is that, as children, they were subjected to strictness, will breaking, demanding discipline; shaming; and the threat of rejection for "bad" and "undesirable" behavior. The loss of emotional support and love, together with shame, instilled in them a drive to avoid rejection at any cost. Repressing, denying, seeking support, and justifying their needs would make adaptive sense in such a situation. It is not surprising that many of them were seen as responsible, likeable children who were cooperative and conscientious. Many did well in school, as one would expect from a conforming approval seeker who is avoiding shameful rejection. These clients may have difficulty

engaging anger toward past parental discipline as they have “identified with the aggressor” by fervently accepting their values. In some cases parents would compare siblings, giving love to the one who was “especially good” and withholding it from the one who was “bad.” In other cases, demands for strict conformity were based on adherence to religious or cultural values. The 3-6 code types want to be seen as “good” at any cost and tend to use language that is evaluative and subtly judgmental, perhaps as an adaptive attempt to prove that they are on the “right side” of any issue.

(Levak, Siegel, Nichols, & Stolberg, 2011)

A 36/63 codetype can be described as the cheerleader/beauty queen/boy scout profile. 36s are conforming, proper, nice, fastidious dressers, and highly sensitive to anything that can be construed as a criticism. These individuals are very self-conscious about their social role. Their polished, controlled demeanor reflects their fears of judgment and their need for approval. Underneath their veneer of exquisite correctness, they are somewhat distrustful and suspicious of others’ motives. This may be a projection of their own tendency to be critical and judgmental, and therefore they anticipate criticism from others. Cooperative and conforming, they live their lives wanting to be above moral reproach. This means that anger and selfish feelings are repressed. They often harbor longstanding resentments, which they tend to rationalize as reasonable and morally justified, and they tend to be self-righteous and unforgiving. These individuals lack insight, living their lives to avoid criticism and judgment from others, but vigilant for how others are hurting them or in some way treating them unfairly. In some cases, this profile is associated with brief psychotic episodes with paranoid jealousies, projections onto others, and self-righteous temper outbursts. However, this codetype is not typically associated with psychosis. The combination of Scale 3 hysteria and Scale 6 paranoia suggests a strong need for approval, sensitivity to criticism, and adherence to rigid values, perhaps as a way of protecting against rejection and criticism. The 36 individual tends to use projection as a primary defense mechanism. Physical symptoms can reflect their over-control, tension, and denial. Though the 36/63 individual can complain of episodic anxiety, these anxiety attacks tend to be brief and situational, with the patient having little awareness of their precipitating cause. These individuals have very high expectations of themselves and others. Some are rigidly religious, reflecting their overcontrol and their tendency to use moral judgment as a way of controlling others. It is not surprising that others find 36 difficult to get along with, although initially attractive and charming, because of their tendency to be so defensive and blaming.

Inhibitions and ambivalences around sexuality tend to be common with this codetype. They have a strong investment in being seen as attractive. However, the vulnerability associated with intimacy is difficult. Interpersonal

problems tend to center around their feelings of being hurt and unfairly treated, and their difficulties with expressing anger and forgiving others.

Their lifestyle is characterized by self-control, the avoidance of criticism, and seeking approval. As children, they tended not to act out, and many were seen as cooperative, conscientious, and model children. A number of 36/63 women were cheerleaders and were well liked by their teachers. Men 36 individuals were described as obedient and well behaved as children (Alex Caldwell, personal communication, 1984). When Scale 6 is significantly higher than Scale 3, then the person is likely to be more suspicious, easily hurt, and judgmental.

o Problems do not seem acute or incapacitating; moderate tension and anxiety; physical complaints; deep---chronic feelings of hostility toward family members; does not express negative feelings directly; may not recognize hostile feelings within self; defiant, uncooperative, hard to get along with; mildly suspicious and resentful; self---centered, narcissistic; denies serious psychological problems; naive, Pollyannaish attitude toward world.

Individuals with this high point pair are seen as angry, bitter individuals who are repressing their own hostile and aggressive impulses. They tend to deny any suspicious attitudes and comfort themselves with a naive and rosy acceptance of things as they are. They perceive their relationships in positive terms and have difficulty understanding why others react to them the way they do. This no doubt contributes to significant marital turmoil. Their chronic feelings of hostility usually are directed toward members of their immediate family. Whenever this anger and hostility are recognized, individuals with this high point pair tend to rationalize so that these feelings appear reasonable, warranted, and justified. They are hypersensitive to criticism, experience considerable anxiety and tension, and frequently have somatic complaints. When Scale 6 is higher than Scale 3 by five or more T points, such clients strive for social power and prestige, even to the point of ruthless power manipulations. The possibility of paranoid or psychotic features should be evaluated in the latter group, even though such traits are relatively unusual for this high point pair. The prognosis for significant change is poor.

o Socially poised but controlling and hyper-rational, with rigidity, overcontrol ("uptight"), egocentricity, paranoid defensiveness, projection, transfer of blame, and covert sadism. Generally tightly composed but subject to periods of anxiety, tension, and somatic symptoms such as headache and upset stomach. Socially skilled and polished but few friends. Oriented to power; extremely avoidant of criticism; can be cruel and ruthless. Inwardly mistrustful, suspicious, and hostile; seeks to control others through allure, manipulations through control of information ("keep 'em guessing"), and power. Expects approval based on appearance, attractiveness, intelligence, status, or some combination of these. Self-righteous; intolerant of others; unforgiving. Stimulates mistrust, dislike, and resentment

in others. Rigidly deny mistrust and hostility. Look for marital and family conflict; conflict with coworkers, especially subordinates.

Symptoms and Behaviors

A 36/63 code type indicates that the person is extremely sensitive to criticism, and represses his or her hostile and aggressive feelings. These individuals are fearful, tense, and anxious, and may complain of physical difficulties such as headaches or stomach problems. Overtly, they might deny suspiciousness and competitiveness, and might even see the world in naively accepting, positive, and perfectionistic terms. They can quickly and easily develop comfortable, superficial relationships. However, as a relationship's depth and closeness increases, their underlying hostility, egocentricity, and even ruthlessness become more apparent.

If Scale 6 is higher than Scale 3 (by more than 5 points), these individuals will attempt to develop some sense of security in their lives by seeking power and prestige.

If Scale 3 is higher than Scale 6 (by more than 5 points), their tendency to blame will be reduced, and such people will be more likely to deny any conflicts or problems. This will be consistent with a tendency to idealize both themselves and their world. They will be more likely to develop somatic complaints rather than paranoid ideation, and the chance of a psychotic process is significantly reduced. They will harbor feelings of resentment and hostility, especially toward family members although they are unlikely to express these feelings directly. At times, they can be naive and gullible.

36/63

Individuals with the 36/63 code type may report moderate tension and anxiety and may have physical complaints, including headaches and gastrointestinal discomfort, but their problems do not seem to be acute or incapacitating. Most of their difficulties stem from deep, chronic feelings of hostility toward family members. They do not express these feelings directly, and much of the time they may not even recognize the hostile feelings. When they become aware of their anger, they try to justify it in terms of the behavior of others. In general, 36/63 individuals are defiant, uncooperative, and hard to get along with. They may express mild suspiciousness and resentment about others, and they are very self-centered and narcissistic. They deny serious psychological problems and express a very naive, Pollyannaish attitude toward the world.

36's

Guthrie noted the similarity of the histories of medical patients with this code to those for the group described above under 34. That is, these patients were also mainly women with gastrointestinal symptoms. However, headaches,

notably absent in the 34 group, did occur among the 36 women. These patients showed a single complaint, rather than an array of symptoms, but like the 34 group their conditions tended not to be serious, acute, or incapacitating. About half of the cases had histories of previous abdominal surgery. Most of these patients were moderately tense and anxious. There was no evidence of paranoid delusions or even prepsychotic conditions. Rather, the paranoid element appeared as deep and often unrecognized feelings of hostility toward members of the subject's immediate family. Where there was awareness of these hostilities toward a parent or marriage partner, the feelings were clearly rationalized. Although their symptoms were well established and fixed, these patients continued to seek medical help. Forsyth and Smith (1967) reported rating data on code 36 patterns appearing among nursing students who were rated by the leaders during a series of group dynamics sessions. These girls differed from other patterns in being more emotional, well thought of, continually asking questions, oversympathetic, not allowing anger to be expressed, and uncomplicated. They were perceived as less manipulative and having fewer problems with authority. (Dahlstrom, Welsh, & Dahlstrom, 1979)

3-6 See the 6-3 combination, p. 182.

1. This individual tends to deny his/her own hostilities, aggressions, and suspicions (Carson, 1969).
2. He/she may be hard to get along with because the underlying hostility and egocentricity of this person are likely to be apparent the closer you get (Carson, 1969).
3. When these two scales are elevated, the person's anger is usually easily seen by others, but the individual typically is unaware of it (Carson, 1969).
4. A person with this pattern may tend to have deep and often unrecognized feelings of hostility toward family members (Hovey & Lewis, 1967). These feelings, when awareness of them exists, are unusually rationalized away. See the 3-4 combination, point 5.
5. He/she may report moderate tension and anxiety, but these do not seem to be acute or incapacitating. The person may be mildly suspicious and resentful of others as well as self-centered (Graham, 1977).
6. Adolescents in treatment with the 3-6/6-3 pattern (Marks et al., 1974) were referred for a variety of reasons. One-third had attempted suicide. They were suspicious, obsessional, and resentful. The Marks, Seeman, and Haller book should be consulted for further information concerning this pattern.

Description

Anxiety, tension, rigidity, fear of criticism, suppressed hostility emerging in passive or episodic aggression, suspiciousness, egocentricity, projection

Possible Diagnoses:

Paranoia, Paranoid p.d., Paranoid schizophrenia, Somatization, Affective dis.

Modifying Scales

- If the Lie scale (L) and the Correction scale (K) are also elevated, the 3-6 is even more rigid and judgmental and has black-and-white values. The L and K add to the overcontrol and the tendency to judge others harshly and to be threatened by any insight-oriented therapy.
- To the extent that Naïveté (Pa3) is elevated, as it virtually always is in this code, the 3-6 code types show increasingly greater rigidity in their black-and-white view of the world and will experience greater difficulty in dealing with anyone whose values are different.
- If Poignancy (Pa2) is elevated, look for extreme sensitivity, easily hurt feelings, and difficulties forgiving.
- If Scale 2 is elevated third, look for a smiling depression with resentments, blame, and harsh judgment of others but with an outward veneer of politeness and social correctness. The underlying depression will tend to be masked by hysterical defenses and manifest itself as a sense of being wounded, or feeling like a martyr.
- If Scale 4 is elevated third, this increases the potential for subtle sexual acting out and passive-aggressive behavior.
- If Scale 8 is elevated, especially if Bizarre Mentation (BIZ), Psychoticism (PSYC), or Aberrant Experiences (RC8) are also elevated, look for odd episodes and brief psychotic breakdowns followed by reconstitution phases. Odd sexual preoccupations, paranoid projections, and jealous and abrupt angry episodes would be typical.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Male

Low 0 One interview only, aggressive or belligerent, wants answers or insists on test scores. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, lack of social skills, mother conflict, being nonresponsive or nonverbal, being nonverbal or a nonrelator, being unrealistic or illogical, nervousness, restlessness, unhappiness.

Female

Low 0 Lacks academic drive, marriage oriented, tense on examinations, socially extroverted, resistant in the interview.

Low 2 Socially extroverted.

Low 4 Shy in the interview.

Low 5 Exhaustion, insomnia, headaches, distractible in study, physical inferiority, home conflict.

Nothing Low Verbal, 8+ conferences, tense on examinations, restless, father conflict, mother conflict.

(Drake & Oetting, 1959)

o **Check:** *ANX, DEP, DEP1, DEP2, HEA1, HEA2, BIZ1, BIZ2, ANG1, ANG2, CYN1* (low), *RC3* (low), *CYN2, ANT1* (low), *ANT2, TPA1, TPA2, SOD1, SOD2* (low), *AGGR, PSYC, DISC, Dr1, Dr3, Dr4, Hy1, Hy2, Hy3, Hy4, Hy5, Pd4, Pa1, Pf1, Pf2, Pf3, Pf4, Pa2, Pa3, Sc1, Sc2, Sc3, Sc4, Sc5, Sc6, Ma4, Si1* (low), *Si2, A, R, O-H, MDS.*

TREATMENT

Look for childhood conditioning experiences of being shamed into conformity by rigid, moralistic caregivers. In some cases, this may have occurred through harsh and heavily rationalized punishments, in other cases, through strong will-breaking criticisms. The 36 individual appears to have over-identified with their caregiver's values, as an adaptive defense against a retaliation response. Consequently, they have learned to judge and shame others whenever they feel that others have acted inappropriately toward them. The 36 individual tends to be defensive in psychotherapy and perceives history taking as a probe for what is "wrong with them." Consequently, they tend to give defensive and socially correct histories, which can be frustrating for the therapist. Because of their defensiveness, they often can aggravate others into expressing anger towards them. This confirms their expectations of conflict. The therapist may feel defensive in response to the 36 self-justifications and subtle blame. They tend to be highly rational individuals who look for specific advice, the "right answer," to a specific problem. A goal of therapy would be to help them understand that feeling anger does not suggest that they are doing something wrong. They tend to see normal human emotions of anger, sexuality, jealousy, and greed as emotions that are bad, and only to be felt when clearly justified. Their childhood experiences of criticism may have taught them that certain emotions are "wrong" and "bad," which has led them into developing stress-relieving avenues to engage or express them. Exploring early experiences of having been criticized or judged, and then using Gestalt techniques to help them express anger at having been judged harshly or unfairly, could begin the process of allowing them to have empathy for themselves and to be less rigid about labeling their emotional state.

Treatment: Rule out paranoid psychosis; paranoid personality. Usually unable to tolerate an inability to control the therapist and the feelings of vulnerability engendered in psychotherapy. Self-righteousness, hyper-rationality, making others responsible for problems, and intolerance of the idea of having "mental problems" are all serious

obstacles in therapy and predict early dropout. Treatments focused on the presenting problem and symptomatic relief may be successful.

Treatment Implications

Their ability to acquire personal insight is limited because they are psychologically unsophisticated and resent suggestions that their difficulties may be even partially psychological (check the TRT/Negative Treatment Indicators scale). They will usually blame their personal problems on others, which creates one of their major difficulties in relationships. In therapy, they will typically terminate abruptly and unexpectedly. They can be ruthless, defensive, and uncooperative. A central issue will be having them take responsibility for their feelings and behaviors.

Therapy and Therapeutic Pitfalls

These clients will tend to be formal and subtly self-denigrating as a way of eliciting flattery and reassurance from the therapist. It's important for them to feel approved and validated. The 3-6 individuals are defensive since their primary concern is to avoid shameful criticism. They go through life justifying to others that they are loveable, desirable, and above all reproach. They are sensitive to being judged as psychologically disturbed, so any probing by the therapist tends to be seen by them as an attempt to judge them or back them into a corner. They tend to want specific advice about their problems and are threatened by insight therapy, as they fear being judged as morally deficient in any way. Once rapport has been established, insight can develop slowly by helping them to understand how they tried hard to please as children and how episodic, humiliating criticism was unfair and experienced by them as shameful and painful. Discover any specific memories where they felt particularly unfairly treated and help them role play, the expression of anger and resentment toward the parents at the time they felt unfairly punished. Catharsis can be quite helpful, especially with reassurance that they are good people. Subtle criticism of the therapist or suggestions that the therapist might be disappointed with them should be dealt with so that rationalized resentments toward the therapist don't build. If clients can express anger toward the therapist without the therapist becoming defensive, this can be helpful to rapport building and gives permission to communicate irritation. Help the clients realize how hard they work to please and to avoid criticism and the costs to them of doing so. They have difficulty expressing what they see as selfish needs or demands; teach them to ask for what they want as soon as they are aware of it rather than waiting until they feel they justified (Braiker, 2001). The long-term goal of therapy is to help them accept all of their emotional life rather than to judge some feelings as unacceptable. (Levak, Siegel, Nichols, & Stolberg, 2011)

Treatment and Self-Help Suggestions

1. Recall with your therapist any moments growing up where you felt unfairly punished, humiliated, and shamed. You have gone through life trying to earn love and approval and to avoid being criticized or judged. You work so hard at it that sometimes you're not as spontaneous as you could be. Work with your therapist to identify any "should" statements that govern your behavior, such as "I should always be nice and pleasing." Write down as many statements as you can think of, and replace them with corrective statements such as, "If and when I want, I can choose to be nice, but I don't have to."¹
2. When you experience mild anger or resentment, force yourself to talk about it with the person, expressing your hurt. Don't wait until you feel completely justified. By the time you ask for what you want, it may come out as a demand because you wait until you feel you are owed something before you are able to ask for it. Assertiveness training can help you to express your desires and hurt feelings in a way that is direct, honest, and respectful. Some popular, online assertiveness training Web sites can be found at www.helpself.com/directory/assertiveness.
3. When your physical symptoms increase in intensity, take time to understand whether you are angry or resentful about something. Your body can serve as a good barometer of stress.
4. Resilience building: Work with your therapist to understand why you tend to take things so personally. Your habitual way of explaining things is called your "explanatory style." People who personalize tend to blame themselves and to negatively interpret events, leading to low self-esteem. Those who attribute setbacks to external factors tend to be more hopeful and resilient. Practice explaining negative events in a non-personal manner.²
5. Learn to accept all your emotions, not just your positive ones. Rehearse with your therapist how to express selfish and self-centered wishes, learning that you are still lovable even when you may ask for things that seem unreasonable. With your therapist, practice speaking your mind, and practice taking care of yourself.

¹ An excellent book to use with your client is *The Disease to Please: Curing the People-Pleasing Syndrome* (Braiker, 2001).

² A review of the literature on the relationship between cognitive style and variance in successful aging and well-being in adulthood and old age finds that one of the factors of well-being is an optimistic explanatory style (Isaacowitz & Seligman, 2003). In athletes a pessimistic explanatory style

constitutes a dispositional risk factor likely to lead to lower expectations of success, to increased anxiety, and to poor achievement (Martin-Krumm, Sarrazin, Peterson, & Famose, 2003).
(Levak, Siegel, Nichols, & Stolberg, 2011)

THERAPEUTIC FEEDBACK LANGUAGE

Your profile shows that you are a person with very strong values. Generally, people will see you as cheerful, polite, and socially appropriate. People with your profile are often seen as attractive and fastidious. You generally follow the rules and your teachers probably appreciated your good behavior. You are quite sensitive and you have high standards. Consequently you experience criticism quite painfully. You try hard to be above criticism and to avoid others judging you in any way. Typically, people with your profile grow up with parents who have strong values and who may have been somewhat strict, if not quite punishing. If you did something they disapproved of, they may have used shame or harsh criticism as a way to discipline you. From an early age you learned to try to do the right thing and to avoid criticism. Perhaps now you are very sensitive to what is “wrong” or “right” and you avoid expressing strong emotions until you feel you are completely justified in doing so. You may go through life unaware that you are constantly careful to avoid doing something that could be judged by others as bad. When you feel normal human emotions, such as anger, jealousy, or resentment, you may find yourself trying to analyze it away, to be rational and fair-minded. Being punished or shamed as a child has made you work very hard to be seen as always doing the right thing, and to avoid experiencing emotions that you see as bad. However, this may now lead to periods of significant stress and you may even experience stress in the form of physical symptoms. Headaches, low back pain, stomach upsets, and other vague and shifting physical symptoms may reflect how hard you’ve worked at trying to be perfect.

Discuss with your therapist any memories you may have of times growing up where you felt punished, humiliated, or shamed, especially if you felt that you were being misunderstood and punished unfairly. Work with your therapist to identify any “should” statements that govern your behavior in which you pass judgment on yourself or others. When you experience mild irritation or hurt feelings, experiment with verbalizing it to the person who has hurt you. Do not wait until you feel that you are justified to do so, because by then you’ll be quite angry and it will be hard for you to forgive. Accept the fact that you are sensitive and do not be self-critical. Learn to accept all your emotions, not just positive ones. You could even rehearse with your therapist how to role-play being selfish and self-centered, just to see what it feels like. Since you are so sensitive when people hurt you, it is hard to forgive. If you can learn to express your emotions it will be easier to forgive others when they have disappointed or hurt you. When irritated with someone, tell them what has upset you but without having to tell them what they have done wrong.

Feedback Statements—Elevated Profiles (T-Score > 65)

Strengths

Your profile reveals that you have a number of positive strengths. You are a controlled, poised, rational, and analytical person who works very hard to do the right thing. You go out of your way to be polite, to follow the rules, to not express negative emotions inappropriately, and to be above others' criticism. You have very high personal standards, and you tend to be your own worst critic. Your values are quite black and white, so having such strong values may make others feel that your standards are inflexible and hard to live up to.

Sensitive to Criticism

Currently, you may be experiencing some fear or anxiety that someone is being critical or judgmental of you. Perhaps someone has hurt you or has been unfairly critical of you so that you are feeling very sensitive to being criticized or judged. You are working hard to stay positive and cheerful, but underneath you may feel vulnerable to judgment or even attack. At times you may even feel a little paranoid, wondering who you can trust and whether other people are saying mean things about you. Occasionally, you may find yourself misjudging others, seeing them as enemies when, in fact, they are not.

Perfectionist

You have very high personal standards, and others may see you as somewhat perfectionist and hard to please because your standards are so hard to live up to. You have developed a remarkable discipline to try to be above all criticism. Typically, people with your profile are meticulous about the way they look and dress and about the way they behave, so etiquette is important to you.

Anxious or Somatic

Although generally positive and even cheerful, you may experience occasional, moments of anxiety. You may not be aware of why you are having these anxious episodes. Because you are a controlled and rational person who tries hard to manage your emotions, you may not recognize when anger and resentment toward others builds up inside of you. Holding those feelings in and not allowing them to be expressed may lead to occasional anxiety attacks or physical symptoms of stress such as headaches, backaches, or stomachaches.

Sexual Inhibitions

You enjoy approval and love from others, so you work at it. Others may find you quite attractive, which you enjoy. However, letting go sexually can sometimes be difficult because you are so controlled and poised. Because you are

aware of any imperfections in yourself and others, relaxing and being uninhibited during sex can be difficult. Also, letting go sexually can be complicated if you feel that the person you're with has in any way been critical of you.

Rigid or Unforgiving

You have very strong values, and you believe that others should behave the right way. When they don't, it's easy for you to take it personally and to feel that bad behavior should be punished. Others may see you as a little rigid or unforgiving.

Jealous or Possessive

Although you are ashamed of experiencing unacceptable impulses, you may find yourself easily jealous or possessive of the people you love. These are normal human emotions, although you may find them unacceptable. As a child, your parents may have made you feel that love and approval had to be earned and could easily be withheld for bad behavior, so you may feel that love is fragile. Jealousy is a fear of loss. You can work with your therapist on why you developed this fear.

Lifestyle and Background Feedback

People with your profile often grew up in environments where a parent was quite strict, perhaps even judgmental and demanding. If you did something wrong, they tended to see it as "bad," and they might have been quite harsh and shaming in the way they punished you. It was important for you to be loved and to have approval, and criticism left you feeling ashamed and emotionally abandoned. You tried hard to please, to be above criticism, and to be the kind of child your parent could love. Often, people with your profile were well liked by their teachers because they were conforming, followed the rules, and avoided doing anything that upset them. To this day, criticism or judgment is very painful to you and can make you quite angry.

Normal-Range Feedback (T-score 50 to 65)

Your profile is well within the normal range and suggests that you are a person who has high standards and works hard to be above criticism. It is probably important for you to be seen as a cheerful, nice, and contented person and you may work hard not to "rock the boat." You have a mild tendency to want to ignore negative aspects of people and to give others the benefit of the doubt. It is probably hard for you to become angry unless you feel completely justified in doing so, so you spend energy trying to analyze your feelings to make sure that they are always appropriate and within reason. You probably find confrontations difficult, and before you deal with someone you likely spend time thinking about things to make sure "they deserve it." Sometimes people with your profile will

bottle up negative feelings and then express them in short, sharp, angry outbursts. You are generally someone who has high self-expectations but who expects others to “do the right thing.” Most people will see you as cooperative, conscientious, and very much a “team player.”

(Levak, Siegel, Nichols, & Stolberg, 2011)

367 Code

Male

Low 0 One interview only, aggressive or belligerent, wants answers or insists on test scores, lacks knowledge or information. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, lack of social skills, mother conflict, being nonresponsive or nonverbal, being nonverbal or a nonrelator, being unrealistic or illogical, nervousness, restlessness, unhappiness.

Low 1 Nonresponsive or nonverbal, home conflict.

Nothing Low Lacks skills with the opposite sex, mother conflict, sibling conflict, nonresponsive or nonverbal, tense, indecisive, unhappy, worries a great deal, insomnia, confused.

- Note: Scale 3 coded high was infrequently associated with mother conflict.

Female

Low 0 Anxieties, insomnia, lacks academic drive, marriage oriented, tense on examinations, socially extroverted, resistant in the interview.

Low 1 Anxieties, insomnia.

Low 2 Anxieties, insomnia, socially extroverted.

Low 4 Anxieties, insomnia, shy in the interview.

Low 5 Anxieties, insomnia, headaches, exhaustion, nervous, distractible in study, socially insecure, physical inferiority, lacks self-confidence, indecisive, home conflict.

- Note: Scale 3 coded high was infrequently associated with social insecurity.

Low 8/9 Anxieties, insomnia.

Nothing Low Anxieties, insomnia, restless, headaches, tense on examinations, verbal, 8+ conferences, father conflict, mother conflict, sibling conflict.

(Drake & Oetting, 1959)

368 Code

Male

Low 0 One interview only, lacks knowledge or information, aggressive or belligerent, wants answers or insists on test scores. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, lack of social skills, mother conflict, being nonresponsive or nonverbal, being nonverbal or a nonrelator, being unrealistic or illogical, nervousness, restlessness, unhappiness.

Low 1/2/4/5/7 Lacks knowledge or information.

Low 9 Introverted or self-conscious or socially insecure, lacks knowledge or information.

Nothing Low Indecisive, unhappy, worries a great deal, insomnia, lacks knowledge or information, confused.

Female

Low 0 Tense on examinations, marriage oriented, lacks academic drive, socially extroverted, verbal, 8+ conferences, resistant in the interview.

Low 1 Verbal, 8+ conferences.

Low 2 Verbal, 8+ conferences, socially extroverted.

Low 4 Verbal, 8+ conferences, shy in the interview.

Low 5 Verbal, 8+ conferences, exhaustion, headaches, insomnia, anxieties, distractible in study, physical inferiority, home conflict.

Low 7/9 Verbal, 8+ conferences.

Nothing Low Verbal, 8+ conferences, depressed, restless, tense on examinations, lacks skills with the opposite sex, father conflict, mother conflict, sibling conflict.

(Drake & Oetting, 1959)

369 Code

Male

Low 0 One interview only, aggressive or belligerent, wants answers or insists on test scores. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, shyness in the interview, lack of social skills, mother conflict, being nonresponsive or nonverbal, being nonverbal or a nonrelator, being unrealistic or illogical, nervousness, restlessness, indecisiveness, unhappiness.

Female

Low 0 Marriage oriented, lacks academic drive, tense on examinations, socially extroverted, verbal, resistant in the interview.

Low 1 Marriage oriented, vague goals, socially extroverted.

Low 2 Marriage oriented, socially extroverted.

Low 4 Marriage oriented, socially extroverted, shy in the interview, nonresponsive.

- Note: Scale 3 coded high was infrequently associated with nonresponsiveness.

Low 5 Marriage oriented, distractible in study, socially extroverted, headaches, insomnia, exhaustion, physical inferiority, verbal, home conflict.

Low 7/8 Marriage oriented, socially extroverted.

Nothing Low Marriage oriented, tense on examinations, socially extroverted, restless, verbal, 8 + conferences, father conflict, mother conflict.

37/73 Codes

Code-Type 3-7/7-3

Descriptors

Complaints

Anxiety, tension, fearfulness, phobias, somatic preoccupations, panic attacks, difficulties with concentration or memory, disturbed sleep, occasional depression, somatic symptoms, low self-esteem, nonassertive

Thoughts

Worried, catastrophizing, approval seeking, conflict phobic, lacking in insight, self-critical, ambivalent, seeks to see every side of an issue

Emotions

Repressing, denying, needy, dependent, easily hurt, depressed moods, approval seeking, phobias

Traits and Behaviors

Ingratiating, approval seeking, self-effacing, needy, manipulatively dependent, anxious, fearful, engaging of others' support and help, conflict avoiding, self-defeating

(Levak, Siegel, Nichols, & Stolberg, 2011)

Therapist's Notes

In the normal range the 3-7 code types have high standards, work hard to be above criticism, and avoid confrontation. They want approval and are self-sacrificing.

They ignore the negative aspects of people and give them the benefit of the doubt. Individuals with a 3-7 code type crave approval at any cost. They are anxious approval seekers, always fearful about losing their emotional connection to others. They can be ingratiating, flattering, self-effacing, and needy, eliciting caretaking behavior from others by being dependent, helpless, and apologetic. During periods of stress, as anxiety increases, they develop numerous physical symptoms. Often, the precipitating event is an overload of responsibilities and a fear of failure with resulting loss of love and emotional support from others. They live in dread that others will be disappointed and

angry with them, leading to their emotional abandonment. Small stressors can cause them panic; their anxiety appears appropriate in direction but overblown in intensity. Scale 2 is often coded third because the high level of anxiety tends to be depleting. Insomnia, eating difficulties, sexual inhibitions, and concentration and memory problems would all reflect the effects on the 3-7 of prolonged anxiety (Bowen, Senthilselvan, & Barale, 2000). It is a human tendency to seek interpersonal closeness and intimacy to varying degrees along a continuum, from a need for continuous connection and approval to a need for interpersonal distance. A need for interpersonal distance could be represented by the 4-8 profile, and its polar opposite would be the 3-7. The 3-7 individuals lack insight and repress and inhibit anger and unacceptable impulses. Although many code types are associated with the repression of impulses, in the 3-7 the repression is associated with the need for affirming connection. Although affable and pleasing, as one would expect from those who are attempting to elicit continuous caretaking behavior from others, they can also become petulant and manipulative, especially when stressed. Their manipulations are not sociopathic but serve to elicit support and reassurance. They manipulate others through charm, guilt, and the expression of pain rather than through distorting the truth. The 3-7 individuals may look to marry a strong, supportive person who takes care of them, but their partners often become exasperated by their neediness and insecurity. They have difficulty asserting themselves and, when stressed, can become quite infantile and demanding. They have difficulty handling responsibilities and become overwhelmed if they feel they are failing. Any angry, impulsive, aggressive, or sexual behavior may incite severe guilt and somatic symptoms as they become preoccupied with being rejected and punished by loved ones. The 3-7 persons are conscientious and worry about responsibilities. Major life events that are stressful tend to overwhelm them. They live in fear that some detail they have overlooked will lead to catastrophe and emotional abandonment. Even when bright and capable, they have difficulty asserting themselves and so may be underachievers. Although they tend to experience depression, even if Scale 2 is not concurrently elevated, it tends to come as a result of emotional fatigue due to their habitual worry. If they become physically disabled, they readily assume the role of invalid, as it meets their need to be taken care of.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Lifestyle and Family Background

Our hypothesis is that their craving for love and approval, to the extent that they're willing to be self-effacing and ingratiating, makes sense as an adaptation to parents who were unpredictably explosive and potentially violent. In response to unpredictable rejections, these clients developed a high level of approval-seeking behavior, in some cases to placate the aggressor. Their lifestyle then replicates this original attachment style by a panicked, clinging, attachment-seeking behavioral pattern, and denial of anger. As children, many were described as conforming, pleasing, self-effacing, and insecure over gaining acceptance by their peers. Some had early attachment problems and had difficulty separating from caretakers; other had childhood infirmities and were highly dependent on protective, although episodically explosive, caretakers. Parents with a 3-7 code type can inadvertently elicit acting-out behavior in children who feel overwhelmed by what they see as clinging and demanding parental behavior.

(Levak, Siegel, Nichols, & Stolberg, 2011)

This codetype is associated with tension, anxiety, insomnia, and psychosomatic complaints as well as with academic underachievement. Fearfulness, anxiety attacks, problems with concentration and memory, occasionally disturbed sleep, and a nonassertive, passive lifestyle characterize these individuals. The 37 individual is self-critical, guilty, and has difficulty making decisions. They catastrophize and are constantly seeking others' approval. They use repression and denial and they are highly dependent on others, sometimes to the point of being co-dependent. For both men and women, Scale 2, 4, or 1 is often the third highest scale.

The profile reflects an individual who is constantly on edge, fearing abandonment by others. The elevation of Scale 3 suggests strong needs for approval, and the elevation on Scale 7 suggests a constant sense of anticipatory dread about its loss; these individuals readily catastrophize small setbacks. They can be ingratiatingly subservient in their attempts to maintain emotional support and minimize anger or conflict. Many report a free-floating anxiety that manifests as an edgy jumpiness and occasional panic attacks. These individuals need a great deal of reassurance and flatter others in order to get it in return. They feel guilty if they assert themselves. Any impulsive or self-centered behavior on their part is followed by guilt and looking for reassurance that they are not going to be rejected.

If Scale 2 is coded third, these individuals will exhibit the smiling depression symptoms associated with the 23/32 profile. They will also experience some symptoms of depression such as insomnia, and general inefficiency. If Scale 9 is coded third, the anxiety associated with Scale 7 tends to be focused on achievement failures and they exhibit a constant fear of unpredictable loss of approval. If *L* or *K* scale is elevated, a superficial control and poise is evidenced, with even more repression and denial than is typical of the 37 individual.

o Anxiety, tension, fearfulness, and rumination, often with phobias or panic attacks. Moderate dysphoria with helplessness, problems in concentration, narrowing of interest, fatigue, and disturbed sleep. Depressed mood often secondary to anxiety. May feel helpless and threatened in the face of decisions and time pressures, and need advance approval, reassurance, and support for choices.

Feels ill and in poor and declining health, and unable to meet responsibilities despite desire to do so. Accepts invalidism to avoid stresses. Behavioral control is adequate, but emotional controls are tenuous and fragile.

Impulsive. Credulous and psychologically naive. Passive and lacking in self-confidence in relations with others; avoids conflict. Often extremely dependent on others for affection, approval, and support; may be seen as clinging, helpless, or ingratiating. Sensitive, timid, and easily hurt; fends off aggression or criticism in others by appearing emotionally fragile and vulnerable.

Tends to locate sources of distress outside the self, in symptoms and in the environment. Look for a history of underachievement, phobic anxiety, ingratiation, current invalidism within family.

3-7

- Some chronic physical symptoms resulting from mental stress is likely with these people (Hovey & Lewis, 1967).
- Women with this combination together with a low scale 0, usually lack academic drive, are anxious, and have insomnia (Drake & Oetting, 1959).

Description:

“Anticipatory worrier”, responsible, use repression and denial, fear loss of control of anger in self or others

Possible Diagnoses:

Depersonalization dis., Somatization, Anxiety dis.

Modifying Scales

- When Scale 2 is coded third, the smiling depression associated with the 2-3 code type will be combined with the hyper-responsible, prone to worry, guilty depression of the 2-7. Low energy, despondency, suicidal ideation, and other symptoms of depression would be prevalent.
- When Scale 4 is elevated, look for acting out in the service of anxiety reduction. Eating disorders, sexual acting out, telling white lies, and other kinds of selective reporting as well as more blatant manipulation

would all serve to immediately reduce anxiety. Although acting out may lead to guilt and anxiety, these are only temporary.

- When Scale 6 is coded third, clients become preoccupied not only with abandonment but also with disapproval. They are threatened by any loss of social status. The 3-6-7 code type would have difficulty making decisions, attempting to anticipate not only all possible eventualities but also all possible criticisms.
- When a 3-7-8 profile, there is more identity damage and difficulty with emotional closeness. The addition of Scale 8 suggests a strong approach–avoidance conflict in close relationships. There can be periods of rumination and obsessions from which the neurotic defenses of the 3-7 help them to recover.
- When the K scale is elevated, the symptoms of anxiety would be more focused and controlled and less diffuse and scattered.
- Typically, the content scales associated with anxiety such as Anxiety (ANX), Obsessiveness (OBS), and Fears (FRS) would all be elevated, but their relative elevations help to clarify the focus of the anxiety. Low Self-Esteem (LSE) and Work Interference (WRK) would also typically be elevated, reflecting their difficulties with self-esteem and decision making.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Male

Low 0 One interview only, lacks knowledge or information, aggressive or belligerent, wants answers or insists on test scores. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, lack of social skills, mother conflict, being nonresponsive or nonverbal, being nonverbal or a nonrelator, being unrealistic or illogical, nervousness, restlessness, unhappiness.

Nothing Low Lacks skills with the opposite sex, mother conflict, sibling conflict, nonresponsive or nonverbal, tense, indecisive, unhappy, worries a great deal, insomnia, confused.

- Note: Scale 3 coded high was infrequently associated with mother conflict.

Female

Low 0 Anxieties, insomnia, lacks academic drive, marriage oriented, tense on examinations, socially extroverted.

Low 1 Anxieties, insomnia.

Low 2 Anxieties, insomnia, socially extroverted.

Low 4 Anxieties, insomnia.

Low 5 Anxieties, insomnia, headaches, exhaustion, nervous, distractible in study, home conflict, lacks self-confidence, indecisive, shy in the interview.

- Note : Scale 3 coded high was infrequently associated with shyness in the interview.

Low 6/8/9 Anxieties, insomnia.

Nothing Low Anxieties, insomnia, headaches, nervous, lacks self-confidence, tense on examinations, verbal, father conflict, mother conflict, sibling conflict.

(Drake & Oetting, 1959)

o **Check:** *ANX, FRS1, FRS2, OBS, DEP1, DEP2, DEP3, DEP3, RC7, HEA3, ANG1 (low), ANG2 (low), ASP1 (low), ASP2, TPA1, TPA2 (low), LSE1, LSE2, AGGR (low), DISC (low), NEGE, Dr1, Dr2, Dr3, Dr4, Dr5, Hy1, Hy2, Hy3, Hy4, Hy5, Pd5, Pa2, Sc2, Sc3, Sc4, Sc5, Sc6, A, R, Re.*

TREATMENT

Typical childhood experiences would include an unpredictably explosive or violent caregiver that terrified the individual. As children, many have been described as conforming, placating, unobtrusive, and wanting to please adults. As adults, they are highly conscientious, responsible, diligent, and anxious about financial or security setbacks. Transitions are particularly troubling for them. They do best in stable, structured, predictable environments. Relaxation training and assertiveness training can be helpful. Sometimes implosion therapy, whereby they can re-experience the terror of a child confronted by a raging parent, can help them learn not to panic about other people's anger towards them. They are suggestible and so make good hypnosis candidates, especially for deep relaxation training. They are vulnerable to experiencing medication side effects. These individuals respond well to reassurance, so motherly, nurturing therapists can be successful. Insight therapy can be difficult because they exhibit repression and denial, but helping them develop a sense of empathy for themselves as frightened children can help them understand the origin of their panic around the threat of others' anger. Rehearsing potentially frightening situations in conjunction with relaxation therapy can help them develop a better sense of control. They tend to oscillate between acute anxiety states, where they need a great deal of reassurance, and periods of denial in which there is a "flight into health." They tend to have a pleasing, smiling disposition with a strong need for the therapist's approval, so they make good candidates for supportive therapy. During insight therapy the patient may become flooded with the accompanying emotions and frightened by their intensity. They develop a very strong positive transference, but if they feel they are disappointing their therapist, they terminate therapy prematurely.

Treatment: Benefit from structure, support, and reassurance but reluctant to focus away from immediate symptoms and perceived sources of distress. Relief of anxiety and fears/phobias may enable other problems to be addressed.

Therapy and Therapeutic Pitfalls

These clients seek reassurance, but once reassured they tend to leave therapy because insight makes them anxious. They anticipate from the therapist the relationship they had with their primary caretaker, which was one of unpredictable rejection. Although the clients will be quite flattering toward the therapist, they have difficulty establishing genuine rapport because of their anxiety about being rebuffed and therefore have difficulty sharing vulnerable emotions. Much of the therapy is about immediate anxiety-provoking situations that are panicking to them. Given the repressive effects of hysteria and anxiety, exploring childhood memories of explosive parents is difficult. Use relaxation training, and help them imagine and have empathy for how another child might have experienced such events to allow them to slowly reexperience explosive incidents without debilitating anxiety. In describing painful conditioning events, clients may report feeling faint, weak, or dizzy; prepare them for such a reaction to help inoculate them from being overwhelmed by emotions. Teach clients how frightening events can precipitate a panicked drive to please and placate others to help them to develop anticipatory coping skills. Assertiveness training and concurrent reassurance that anger and demanding things from others does not have to lead to rejection are also useful. Gestalt therapy can help clients engage their repressed emotions. Systematic desensitization training to deal with fears and phobias may also be useful (McGlynn, Smitherman, & Gothard, 2004). Problem-solving therapy (PST) is a cognitive-behavioral intervention that focuses on training clients in adaptive problem-solving attitudes and skills, and has been demonstrated to have utility in treating generalized anxiety disorder (Dugas et al., 2007). (Levak, Siegel, Nichols, & Stolberg, 2011)

Treatment and Self-Help Suggestions

1. You have likely sought help because your anxiety feels overwhelming. Because anxiety disorders, as a group, are the most common mental health problems in the United States,¹ there are many effective and well-researched treatments available. The suggestions that follow will outline effective treatments, but for general information about anxiety disorders you can contact the National Institute of Mental Health (NIMH) toll free at (888) ANXIETY or (888) 269-4389. The NIMH Website is <http://www.nimh.nih.gov>.
2. Work with your therapist to identify how automatic negative thoughts (ANTs) influence your feelings and your behavior. With practice, you can change the negative thought patterns that lead to anxiety. Pay attention whenever you have a strong feeling or reaction to something, and notice what goes through your mind. Examples of ANTs include, “I will never get this right,” “I should have known better,” or “I am sure that she doesn’t like me.”²

3. Explore with your therapist what is currently stressing you. You may focus on your anxiety and your physical symptoms as the cause of your problems, but there is likely a deeper issue. Perhaps responsibilities have accumulated, and you are having trouble with effective problem solving. While worrying is counterproductive, problem solving is a constructive thought process focused on effectively dealing with the issue. Approaching one concern at a time, use a journal, write it down, and then list all the possible solutions you can think of. Identify the most helpful solution, and decide on a specific plan. Once you have carried out your plan, evaluate the outcome to determine if it has been effective or if it needs to be revised.³
4. In addition to personal responsibilities mounting up, you may also be experiencing anxiety because you're worried that someone who has always been supportive is now becoming angry or even beginning to distance themselves from you. Work with your therapist to detect any *cognitive distortions* or *irrational beliefs* that might be contributing to this feeling. Some examples of irrational beliefs are *mind reading* (believing you know what others think or feel without asking); *either-or* (viewing people in all or nothing terms with no shades of gray); or *negative fortune telling* (predicting the future negatively). Your therapist can help you challenge these unproductive beliefs as well as any underlying core beliefs so that you can change this pattern of negative thinking.⁴
5. Learn to recognize when anxiety is building, and work with your therapist to practice relaxation techniques. Controlled breathing helps because when people are tense their breathing is shallow, which sets up a pattern of imbalance of oxygen and carbon dioxide that then increases anxiety. Practice at least 4 minutes at a time, as this is how long it takes to restore balance. Place one hand on your upper chest and one hand on your stomach so that the hand on your stomach moves as you breathe in to a slow count of 4 and breathe out to a slow count of 4.⁵
6. Progressive Muscle Relaxation (PMR) is also helpful in combating anxiety. In PMR major muscle groups are first tensed and then relaxed proceeding from the feet to the head or vice versa. Each muscle group is tensed for 5 seconds and relaxed for 10 to 15 seconds. The more you practice the more skilled you will become at controlling anxiety.⁶

7. If you have any specific fears and phobias, cognitive-behavioral therapies such as systematic desensitization have an effectiveness rate as high as 80%.⁷ A comprehensive Web site about phobias is http://helpguide.org/mental/phobia_symptoms_types_treatment.htm.
8. Learn to ask for what you want; you have a tendency not to think about that because you are so busy trying to please others and to figure out what they want. Assertiveness training would be a useful tool in helping you express your needs.
9. Role play standing up for yourself with your therapist, and experience the frightening feeling associated with that. Learn to understand that those frightening feelings come from your childhood where you weren't allowed to assert yourself. Instead, you tried to stay connected with the adults in your life at almost any cost. Your therapist may want to use gestalt techniques to help you become comfortable expressing strong feelings without being scared of them.

¹ GAD and other anxiety disorders such as panic attacks, phobias, obsessive-compulsive disorder, and posttraumatic stress disorder are among the most common mental health problems (Kessler, Chiu, Demler, & Walters, 2005).

² Cognitive-behavioral therapy has been well established as an effective treatment for anxiety in both laboratory and real-world therapy settings (Stewart & Chambless, 2009) and in meta-analysis was as effective as pharmacological treatment and was associated with long-term treatment gains, whereas treatment gains attenuated following medication discontinuation (Gould, Otto, Pollack, & Yap, 1997).

³ PST is a cognitive-behavioral intervention that focuses on training in adaptive problem-solving attitudes and skills and has been demonstrated to have utility in treating GAD (Dugas et al., 2007).

⁴ More than 50 types of distorted thinking have been identified (Beck, 1976; Ellis & Dryden, 1997; Leahy & Holland, 2000; Smith, 2002). A good source to help clients change distorted beliefs is *Mind Over Mood* (Greenberger & Padesky, 1995).

⁵ The controlled breathing technique is detailed in *Mind Over Mood* (Greenberger & Padesky, 1995, p. 185). Deep breathing was found to reduce stress, nervousness, and self-doubt in a group of 64 students in a 2-year longitudinal study (Paul, Elam, & Verhulst, 2007).

⁶ Chen et al. (2009) found that the degree of anxiety improvement in a progressive muscle relaxation training group was significantly higher than their control group and that it is a useful intervention across a spectrum of psychiatric disorders.

⁷ From *Getting Help: The Complete & Authoritative Guide to Self-Assessment & Treatment of Mental Health Problems* (Wood & McKay, 2007, p. 99).

(Levak, Siegel, Nichols, & Stolberg, 2011)

THERAPEUTIC FEEDBACK LANGUAGE

People with your profile are described as pleasant, nice, and wanting to please others. You are seen as quick to smile and be agreeable. You avoid conflict and go the extra mile to make sure no one's feelings are hurt. When you assert yourself, or if you get angry, it is easy for you to feel guilty and become preoccupied that you have somehow offended others by your feelings. Sometimes people with your profile grew up in environments where a parent was explosive, perhaps frighteningly so. From an early age you tried to please and to predict what kind of situations would upset your parent so that you could avoid them. Maybe that is why you've learned the role of pleaser. It is as if you're always on edge, experiencing a constant sense of anxiety or even dread, worried that you're doing something wrong and that someone you care about is going to be angry with you. If you ask for what you want or are firm with someone, it is easy for you to feel guilty, as if you're going to be abandoned for doing so. Having had a parent who was explosive or frightening, you adapted by learning to avoid ever upsetting them. Now it is hard for you to upset anyone. However, it often comes at your own expense, so you are less able to assert yourself and even think about your own wants. People with your profile often experience periods of severe anxiety, especially if they feel someone is angry with them or they have somehow failed someone. Anxiety disorders are the most common problems that people face, and there are many effective well-researched treatments available. Work with your therapist to identify how you are readily overwhelmed by negative thoughts and anticipations of catastrophe. With practice you can change the negative thought patterns that lead to anxiety. Examples of an automatic negative thought include: "I will never get this right," "I should have known better," or "I'm sure that she is angry with me."

Work with your therapist to see if you are currently panicked about someone being angry with you or withdrawing from you, and make sure that you're not just catastrophizing.

Relaxation training, mindfulness therapy, and assertiveness training may all be helpful to you.

Feedback Statements—Elevated Profiles (T-Score > 65)

Strengths

Your profile indicates you have a number of strengths. You try hard to be positive, to get along with people, and to avoid conflict. You tend to be very detail oriented, and you worry about things going wrong. You care deeply about people and your relationships, and you try hard to please. You are a very conscientious person, and you take your responsibilities seriously.

Anxiety

Your tendency to worry and to avoid conflict may be working against you. Currently, you appear to be quite anxious, on edge, and tense, always feeling a knot in your stomach as if something bad is about to happen. You may be experiencing some stress around your responsibilities or, perhaps, fear that people you care about are angry with you.

Approval Seeking

Anger has always been difficult for you to handle, whether it's your anger toward others or others' anger toward you. If people are upset with you, you fear that you're going to be abandoned and rejected. You tend to hold in your feelings, trying to be understanding of others, and if you do get mad you often feel guilty. You live with fear that something bad will happen and that others will withdraw from you.

Depression or Somatic Symptoms

Your profile suggests that you experience anxiety that seems to come and go, sometimes without even knowing where it's coming from. At times, this stress may wear you out, leaving you feeling depressed, even though you try hard to stay positive. Living with continual worry not only wears you down, but also may cause you to experience some physical symptoms. You may have a difficult time getting to sleep, or you may fall asleep but wake up in the middle of the night, fearing things might go wrong. You may also have other physical symptoms of stress such as headaches, stomachaches, low back pain, or other vague and shifting symptoms, reflecting how tense you currently feel.

Fears Rejection or Seeks Affection

You try hard to be a good person and to avoid doing something wrong. It's hard for you to let your guard down and to let people know all your true feelings because you live with such dread of being rejected and abandoned. It's hard for you to let yourself be spontaneous and to take time to explore your own feelings because you feel threatened by the possibility of anger directed at you by people whom you love and care about. You are an affectionate person, and you crave the warmth of close relationships. You work hard to try to please others, perhaps even reminding them of all the things you love about them, hoping to ensure their love in return. It's so important for you to feel close and connected that you will do almost anything to get people's love and approval, even denying your own feelings to avoid any conflict.

Dependent

When people you care about are not supportive or when they get impatient with you because they feel like your anxiety, worry, and neediness is overwhelming, it hurts your feelings deeply. You may try numerous ways to get people to take care of you, sometimes even by making them feel guilty. It's hard for you to assert yourself, to ask for what you want directly, or to tell anyone off when you're angry with them. You feel safest when you have people around you who are willing to take care of you, to reassure you, and to give you small favors so you feel loved and secure.

Lifestyle and Background Feedback

It's not surprising that you feel this way. Perhaps you grew up in an environment where a parent was supportive of you but also could be explosive, angry, and even frightening. You were probably a sensitive child who loved to please others. You were likely an approval seeker, avoiding disappointing or making adults angry. Some children are loud and boisterous; others are rebellious and angry; and still others are meek and withdrawing. You were nice, avoided conflict, and loved approval from adults. You were probably not that demanding. Perhaps you were also an anxious child, worried about losing your parents' support and maybe concerned about being separated from them. Having a parent who could be explosive must have been scary. No wonder you have worked hard most of your life to avoid any anger or rejection from anyone. Anger from others could restimulate the scar tissue of your early childhood, where you felt terrified that a parent's anger would lead to you being rejected and all alone.

Normal-Range Feedback (T-score 50 to 65)

Your profile is in the normal range and reveals that you have a number of strengths. You test as a sensitive and thoughtful person who works hard to avoid confrontation and hurting people's feelings. Generally, you are a responsible person and are concerned about financial and emotional security. You may also have a tendency to worry "ahead" about the occurrence of some unpredictable event that could cause you problems. During stressful times, you may be prone to developing physical symptoms, perhaps a headache, backache, or stomach upset. If stress becomes severe, you may suffer from an occasional sleepless night or reduced interest in sex. Because of your sensitivity to others and your dislike of confrontations, you may find yourself glossing over things that upset you and even covering up your anger. You are considerate, attentive to details, and caring about other people's feelings. (Levak, Siegel, Nichols, & Stolberg, 2011)

Male

Low 0 Introverted or self-conscious or socially insecure (78), one interview only, nonresponsive or nonverbal (78), tense, indecisive, lacks knowledge or information, vague goals, confused, aggressive or belligerent, wants answers or insists on test scores.

- Note: Scale coded low was infrequently associated with indecisiveness. This pattern was infrequently associated with introversion or self-consciousness or social insecurity (3-0), lack of social skills, mother conflict, being nonresponsive or nonverbal (3-0), being nonverbal or a nonrelator, being unrealistic or illogical, nervousness, restlessness, unhappiness.

Low 1/2/4/5/6/9 Introverted or self-conscious or socially insecure, nonresponsive or nonverbal, tense, indecisive, lacks knowledge or information, vague goals, confused.

Nothing Low Introverted or self-conscious or socially insecure, lacks skills with the opposite sex, mother conflict, sibling conflict, nonresponsive or nonverbal, tense, indecisive, xmhappy, worries a great deal, insomnia, lacks knowledge or information, vague goals, confused.

- Note: Scale 3 coded high was infrequently associated with mother conflict.

Female

Low 0 Anxieties, insomnia, nervous, lacks self-confidence, verbal, marriage oriented, lacks academic drive, tense on examinations, socially extroverted.

- Note: Scale coded low was infrequently associated with lack of self-confidence.

Low 1 Anxieties, insomnia, nervous, lacks self-confidence, verbal.

Low 2 Anxieties, insomnia, nervous, lacks self-confidence, verbal, socially extroverted.

- Note: Scale 2 coded low was infrequently associated with lack of self-confidence.

Low 4 Anxieties, insomnia, nervous, lacks self-confidence, verbal.

Low 5 Anxieties, insomnia, nervous, headaches, exhaustion, lacks self-confidence, indecisive, verbal, distractible in study, socially insecure, home conflict.

- Note: Scale 3 coded high was infrequently associated with social insecurity.

Low 6/9 Anxieties, insomnia, nervous, lacks self-confidence, verbal.

Nothing Low Anxieties, insomnia, depressed, headaches, exhaustion, nervous, lacks self-confidence, verbal, 8+ conferences, tense on examinations, lacks skills with the opposite sex, father conflict, mother conflict, sibling conflict.

Male

Low 0 Home conflict, one interview only, lacks knowledge or information, aggressive or belligerent, wants answers or insists on test scores, defensive. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, shyness in the interview, lack of social skills, mother conflict, being nonresponsive or nonverbal, being nonverbal or a nonrelator, being unrealistic or illogical, nervousness, restlessness, indecisiveness, unhappiness.

Low 1 Home conflict, defensive, nonresponsive or nonverbal.

- Note: Scale 9 coded high was infrequently associated with being nonresponsive or nonverbal.

Low 2/4/5/6/ Home conflict, defensive.

Nothing Low Lacks skills with the opposite sex, home conflict, mother conflict, sibling conflict, nonresponsive or nonverbal, tense, indecisive, unhappy, worries a great deal, insomnia, confused, defensive.

- Note: Scale 3 coded high was infrequently associated with mother conflict; Scale 9 coded high was infrequently associated with lack of skills with the opposite sex, being nonresponsive or nonverbal, indecisiveness, worrying a great deal.

Female

Low 0 Anxieties, insomnia, nervous, exhaustion, marriage oriented, distractible in study, tense on examinations, lacks academic drive, socially extroverted, verbal, confused, sibling conflict.

- Note: Scale coded low was infrequently associated with exhaustion, confusion, sibling conflict.

Low 1 Anxieties, insomnia, nervous, marriage oriented, distractible in study, vague goals, socially extroverted, confused, sibling conflict.

- Note: Scale 1 coded low was infrequently associated with sibling conflict.

Low 2 Anxieties, insomnia, nervous, marriage oriented, distractible in study, socially extroverted, confused, sibling conflict.

- Note: Scale 2 coded low was infrequently associated with confusion.

Low 4 Anxieties, insomnia, nervous, marriage oriented, distractible in study, socially extroverted, shy in the interview, nonresponsive, confused, sibling conflict.

Low 5 Anxieties, insomnia, nervous, headaches, exhaustion, marriage oriented, distractible in study, socially extroverted (39), socially insecure (7-5), verbal, confused, lacks self-confidence, indecisive, sibling conflict, home conflict.

Low 6/8 Anxieties, insomnia, nervous, marriage oriented, distractible in study, socially extroverted, confused, sibling conflict.

Nothing Low Anxieties, insomnia, nervous, headaches, marriage oriented, distractible in study, tense on examinations, socially extroverted, verbal, confused, sibling conflict, father conflict, mother conflict.

(Drake & Oetting, 1959)

[38/83 Codes](#)

(see also Scales 3 and 8)

Code-Type 3-8/8-3

Descriptors

Complaints

Neurological or somatic symptoms, forgetfulness, losses of consciousness, cognitive difficulties, difficulties with concentration and memory, possible psychotic episodes, restless, agitated, irritable

Thoughts

Fractured or autistic thinking, possibly psychotic episodes, dissociative, difficulties concentrating, religious or sexual preoccupations, bizarre preoccupations, difficulties with concentration and memory, loose and bizarre associations

Emotions

Moody, fearful, excitable, agitated, restless, irritable, despondent, episodic depression, suicidal thoughts

Traits and Behaviors

Schizoid, immature, dependent, conflict adverse, odd or bizarre preoccupations, possible psychotic episodes

(Levak, Siegel, Nichols, & Stolberg, 2011)

Therapist's Notes

In the normal range, individuals with 3-8 code types dislike anger and confrontation and try to stay positive and cheerful. They often are imaginative and creative with an active fantasy life. At higher elevations, this code type represents a strong approach-avoidance conflict in regard to primary relationships. Scale 3 predicts strong attachment and approval seeking behavior, and Scale 8 implies strong distancing behavior. The 3-8 code type is contradictory in that hysterical and neurotic defenses combine with poorly organized thought processes. The interaction produces an affable, attention-seeking individual whose thought processes and emotions break down in stressful situations, revealing cognitive slippage and odd emotional episodes. These clients often relate to people in an odd way, and their conversations are lacking in structure and consistency. In discussing emotionally loaded topics, they may be interrupted by loose and even bizarre associations, so that it becomes difficult to track their train of thought. Their thought processes tend to be impressionistic and symbolic, and they experience abrupt and

changeable emotional states. Their affect is often inappropriate to their thought content; for example, they may smile while discussing painful emotions.

(Levak, Siegel, Nichols, & Stolberg, 2011)

They function well within highly structured situations, but in less structured instances the 3-8 code types can experience brief psychotic episodes that seem to get promptly alleviated by hysterical defenses. They can experience dissociative episodes, and they also report bizarre and disturbing preoccupations that often have a religious or sexual focus. They can show periods of excitability, restlessness, and irritability that may appear initially as manic because of their intensity; however, these episodes are usually transient and associated with stressful situations. Some 3-8 clients report dramatic visual or auditory hallucinations, which seem to be brief, acute, and rapidly incorporated into some fanciful explanation. They describe difficulties in concentration and memory, and open-ended questions can be challenging for them. These individuals may complain of emotional emptiness and dysphoria associated with their difficulties with emotional closeness. They tend to think in unconventional ways and can be quite rigid about their own ways of doing things, even though they may appear somewhat eccentric, if not bizarre. Their unusual religious beliefs provide some internal structure for their disorganized internal world. While they are fearful of real intimacy and, therefore, sexual contact, they are often sexually preoccupied, have sexual identity confusion, or interest in particular fetishes. These sexual preferences usually are symbolic of their approach–avoidance conflict in intimate relationships, as they allow sexual expression while maintaining emotional control and distance. The 3-8 individuals have difficulty with conflict and confrontation, and anger can be expressed in odd, symbolic ways. Even when Scale 1 is not also elevated, they will likely experience some somatic symptoms, and they may complain of agitation, sleep disturbance, periods of feeling hopeless and worthless, and some even express suicidal ideation. When stressed they withdraw into daydreaming and fantasizing in nonproductive ways. They are immature and seem to work out problems in unrealistic, fanciful ways that others may find annoying and unreliable.

Lifestyle and Family Background

The 3-8 code types have difficulty dealing with interpersonal conflict, perhaps because of childhoods in which there was conflict and some kind of cruelty associated with rejection. Look for parental figures who were both loving and cruel. A hovering, overly involved, overly protective parent who would show episodes of cold or angry malice might instill in a child intense, ambivalent feelings and ambivalent attachment-seeking behaviors. Expressing warmth toward the hostile parent in roundabout, symbolic ways would provide a buffer against the possibility of being

rejected. The 3-8 clients seek to maintain connectedness but, at the same time, retreat into fantasy, feeling easily panicked and overwhelmed by intimacy.

(Levak, Siegel, Nichols, & Stolberg, 2011)

This is an uncommon codetype. The Scale 3 elevation predicts hysterical defenses and a hysterical personality organization in a profile that is neurotic, whereas the elevation on Scale 8 reflects the possibility of psychotic-like thought processes. The combination of these scales is unusual, suggesting an individual who may be defending against an underlying psychotic thought process with hysterical defenses. The symptoms, complaints, and personality traits of the 38/83 codetype reflect the interaction of these two contradictory defenses. Multiple cognitive and neuropsychological symptoms are often present. These individuals' attention span tends to be fragmented and they are often quite forgetful. Odd somatic symptoms such as loss of consciousness, dizzy spells, dissociative episodes, as well as a variety of sensorimotor and musculoskeletal symptoms are typical. These individuals are seen as strange and peculiar, both in thought and action. An extreme example would be the giggling schizophrenic accosting people on the street corner, dressed in colorful clothes and bright lipstick, clearly psychotic. Although they fear closeness and feel alienated from others, they also have strong needs for affection. When they attempt to achieve an affectionate response from others, they typically do so in immature ways that may serve to actually push others away. They manifest loose associations, with intense and fluctuating moods that are often inappropriate, such as giggling at a sad story or getting angry at a tender moment. Some experience brief and abrupt psychotic episodes, which are characterized by feelings of unreality, emotional inappropriateness, and vague and bizarre somatic complaints. These individuals are often sexually preoccupied, though actual sexual contact is less common because of their fears of emotional closeness and its accompanying vulnerability. Psychotic episodes may disappear quickly once composure is regained, and then the episode is repressed or disassociated. Conceptually, hysterical defenses act as "ego glue," with the thought disturbances erupting occasionally when the individual feels stressed. These individuals can function relatively well and do not evidence psychotic episodes in structured situations. However, even when not stressed, they are likely to manifest dissociative symptoms, inappropriate affect, and bizarre sexualized, violent, and/or religious preoccupations. Some may occasionally experience hallucinations. These individuals experience difficulty with spontaneous conversation. They are easily "blocked" and distracted, so that the stream of conversation tends to become interrupted and the therapist may periodically wonder, "How did we get to this point?" This "blocking" and circumstantial thinking reflects the 38 individual's tendency to experience internal interruptions around emotionally charged material. Sometimes 38 individuals become involved in bizarre religious and/or sexual activities. They commonly have problems expressing anger. Even if Scale 2 is not significantly elevated,

these individuals often appear depressed, as their affect is flat. They react to frustration intropunitively, and they also experience periods of anxiety, tension, and nervousness. Easily threatened, some experience phobias. If Scale 1 is elevated, there may be more vague somatic symptoms, such as blurred vision, dizziness, numbness, and headaches (see 138/318 code). These individuals often present with numerous physical complaints that are difficult to diagnose, and they often seek out numerous diagnostic tests. They are most often the youngest children in the family and seldom the oldest. In the Marks and Seeman (1963) sample, childhood health was reported as good, as was academic achievement, with many of them doing above-average work in school and a large proportion educated beyond the high school level. However, for many, one or both caregivers were alcoholic and some had a caregiver who was also mentally ill. Fathers tend to be affectionate, yet domineering.

- o Intense psychological turmoil; anxious, tense, nervous; fearful, worried; phobias; depression and feelings of hopelessness; can't make even minor decisions; wide variety of physical complaints; vague and evasive when talking about complaints and difficulties
- o Immature, dependent; strong needs for attention and affection; intropunitive; apathetic, pessimistic, not actively involved in life situation; unoriginal, stereotyped approach to problems; insight---oriented therapy not effective, but responsive to supportive therapy
- o Disturbed thinking; problems in concentration; lapses of memory; unusual, unconventional ideas; loose ideational associations; obsessive ruminations; delusions, hallucinations, irrelevant, incoherent speech may be present; most common diagnosis is schizophrenia

Individuals with this high point pair typically have major thought disturbances (if F is greater than or equal to 70) to the point of disorientation, difficulty with concentration, and lapses of memory. Regression and autistic overideation may be present, and thinking may become delusional in nature. Feelings of unreality and emotional inappropriateness are likely. Also evident is a moderate degree of psychic distress that may be discharged into somatic complaints, especially headaches and insomnia. Individuals with this high point pair are generally fearful, emotionally vulnerable, immature, and possess schizoid characteristics. They have an exaggerated need for attention and affection from others, but are quite threatened by intimacy and dependent relationships. They display intropunitive reactions to frustration and approach problems in a stereotyped manner. The most common diagnosis is schizophrenia, but somatoform as well as hysterical disorders should also be considered. Supportive psychotherapy seems to have some limited impact.

o Multiple cognitive and neuropsychological symptoms, including unstable attention, forgetfulness, impaired judgment, losses of consciousness, intrusive and frightening thoughts, and cognitive disruption, as well as a variety of motor, sensory, and musculoskeletal symptoms. Meandering stream of thought; drifts off point. Symptoms may be bizarre and delusional. Anxious and depressed, with depression less evident in depressed mood than in apathy, affective blunting, anhedonia, agitation, vegetative symptoms (including sleep disturbance and fatigue), and depressive cognition and attitudes (pessimism, helplessness, hopelessness, worthlessness), including suicidal ideation. Hopelessness makes suicide a significant risk. Feels ill and in declining health. Prone to brief psychotic episodes of abrupt onset and subsequent amnesia; these may involve flamboyant bizarreness, sexual or religious themes, ideas of reference, delusions of persecution or control, somatic delusions, and visual hallucinations. Spends much time in fantasy and daydreaming. Fantasy may emphasize idiosyncratic, if not bizarre, violent, religious, or sexual themes, and may be frightening. Internally chaotic, with unstable controls and proneness to brief affective storms, with restlessness, demandingness, or angry outbursts. Not generally hostile. Adequate social skills but immature, dependent, and easily upset by conflict with others. Sexual and sexual-identity concerns. Family conflicts and resentments.

Symptoms and Behaviors

This somewhat rare code involves symptoms of anxiety, depression, and complaints such as headaches, gastrointestinal disturbances, and numbness. They may have a series of obscure, intractable somatic complaints. If Scale 8 is significantly higher than Scale 3, these individuals may also have thought disturbances including mental confusion, disorientation, difficulties with memory, and, at times, delusional thinking (check the BIZ/Bizarre Mentation scale). They often experience considerable turmoil and feel tense, fearful, and worried. Outwardly, they might appear apathetic and withdrawn. Although they have unusual experiences related to their thought processes and feel socially alienated, they also have strong needs to appear normal and strong needs for affection. They feel that, if others knew how unusual their experiences were, they would be rejected. Thus, they are extremely afraid of dependent relationships. To protect themselves, they use extensive denial, which makes their capacity for insight poor. They typically will describe their difficulties in a vague, guarded, and nonspecific manner. An important variation from the 38/83 code occurs when elevated Scales 3 and 8 are also accompanied by elevations on *K*, with a low *F*. Persons with this profile are likely to be affiliative, inhibited, and over-conventional, and to have an exaggerated need to be liked and approved of by others. Frequently, they maintain an unrealistic yet unassailable optimism. They emphasize harmony, perhaps even at the cost of sacrificing their own needs, attitudes, and beliefs. Furthermore, individuals who have high 3s with low *F* scores are extremely uncomfortable with anger and will avoid it at all costs. Typically, they will also avoid independent decision making and many other situations in which

they must exert their power. Because they have an exaggerated sense of optimism and deny their personal conflicts, these individuals rarely appear in mental health clinics. It is almost as if any feelings of anger, tension, or defeat are intolerable. Such feelings seem to represent both a personal failure and, perhaps more importantly, a failure in their attempts at controlling their world by developing an over-conventional, exaggeratedly optimistic, and inhibited stance.

When Scale 3 is relatively higher than Scale 8, and 8 and/or *F* is less than 70, somatoform or dissociative disorders are important considerations. If 8 and *F* are both highly elevated, the person might be schizophrenic.

Personality and Interpersonal Characteristics

Persons with this profile can be described as having strong needs for attention and affection and are also immature and dependent. On the surface, they might seem conventional, stereotyped, and unoriginal. Despite having a number of unusual internal experiences, they are uncomfortable with these processes and tend to limit them by being intro-punitive.

38/83

Persons with the 38/83 code type appear to be in a great deal of psychological turmoil. They report feeling anxious, tense, and nervous. Also, they are fearful and worried, and phobias may be present. Depression and feelings of hopelessness are common among 38/83 individuals, and they have difficulties in making even minor decisions. A wide variety of physical complaints (gastrointestinal and musculoskeletal discomfort, dizziness, blurred vision, chest pain, genital pain, headaches, insomnia) may be presented. 38/83 persons tend to be vague and evasive when talking about their complaints and difficulties.

38/83 persons are rather immature and dependent and have strong needs for attention and affection. They display intro-punitive reactions to frustration. They are not involved actively in their life situations, and they are apathetic and pessimistic. They approach problems in an unoriginal, stereotyped manner. The 38/83 code type suggests the presence of disturbed thinking. Individuals with this code type complain of not being able to think clearly, of problems in concentration, and of lapses of memory. They express unusual, unconventional ideas, and their ideational associations may be rather loose. Obsessive ruminations, blatant delusions and/or hallucinations, and irrelevant, incoherent speech may be present. The most common diagnosis for psychiatric patients with the 38/83 code type is schizophrenia, but they are sometimes diagnosed as having somatoform disorders. Although response to insight-oriented psychotherapy is not likely to be good for 38/83 persons,

they often benefit from a supportive psychotherapeutic relationship.

1. These people complain of problems in thinking clearly (Hovey & Lewis, 1967).
2. Possibly they may have delusional thinking (Hovey & Lewis, 1967).
3. They may have much psychological turmoil and have difficulty making even minor decisions (Graham, 1977).
4. People with this combination may have brief, highly sexualized psychotic episodes, for which they are amnesic (Trimboli & Kilgore, 1983).
5. Marks, Seeman, and Haller (1974) found this 8-3/34 pattern in a university hospital and outpatient clinic. This profile tended to be of a woman who was having difficulties thinking and concentrating. She usually was seen by others as apathetic, immature, and dependent. The Marks, Seeman, and Haller book should be consulted for further information concerning this profile.
6. College students with this pattern tend to be indecisive, confused, worrying, and report a lack of knowledge or information (Drake & Oeuving, 1959).

Description:

Confusion, distress, anxiety attacks, histrionic, narcissistic, dependent, lapses of memory, poor concentration, unusual ideas, loose associations, may have delusions and hallucinations

Possible Diagnoses:

Multiple personality, Pedophilia, Schizophrenia, Somatization, Psychosis, Affective dis.

Modifying Scales

- o When Scale 1 and Health (HEA) or Somatic Complaints (RC8) are elevated, look for numerous physical symptoms and somatic preoccupations, especially Sensorimotor Dissociation (Sc6) and Neurological Symptoms (HEA2), some of which may be quite bizarre. The somatic symptoms would increase in severity during periods of stress.
- o When Scale 2 is elevated, then complaints of depression, despondency, and suicidal ideation increase. The elevation of Scale 2 would also increase the likelihood of severe difficulties with memory, concentration, thinking, and the manifestations of vegetative signs of depression.

- o Scale 4 coded third can indicate impulsive breakthroughs of cruel anger followed by denial and a lack of awareness of the effects of their behavior.
- o When Scale 6 is coded third, these clients may exhibit brittle over-control with angry temper outbursts when they feel unjustly treated. Elevations of Scale 6 increase the likelihood of psychotic episodes, especially if Persecutory Ideas (Pa1) is the highest of the Harris and Lingoes subscales.
- o When Bizarre Mentation (BIZ), Psychoticism (PSYC), or Aberrant Experiences (RC8) are elevated, the possibility of brief psychotic episodes increases. During these periods, clients may exhibit inappropriate sexuality mixed with odd religious themes. Hallucinations and various hysterical somatic symptoms may also be present.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Male

Low 0 One interview only, lacks knowledge or information, aggressive or belligerent, wants answers or insists on test scores. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, lack of social skills, mother conflict, being nonresponsive or nonverbal, being nonverbal or a nonrelator, being unrealistic or illogical, nervousness, restlessness, unhappiness.

Low 1/2/4/5/6/7 Lacks knowledge or information.

Low 9 Lacks knowledge or information, introverted or self-conscious or socially insecure.

Nothing Low Lacks knowledge or information, confused, unhappy, worries a great deal, insomnia, indecisive.

Female

Low 0 Verbal, lacks academic drive, marriage oriented, tense on examinations, socially extroverted.

Low 1 Verbal.

Low 2 Verbal, socially extroverted.

Low 4 Verbal.

Low 5 Verbal, insomnia, headaches, exhaustion, anxieties, home conflict, distractible in study.

Low 6/7/9 Verbal.

Nothing Low Verbal, depressed, lacks skills with the opposite sex, 8+ conferences, tense on examinations, sibling conflict, father conflict, mother conflict

(Drake & Oetting, 1959)

o **Check:** *CogProb, DisOrg, ANX, FRS1, DEP1, DEP2, DEP3, DEP4, Hp, HEA1, HEA2, HEA3, BIZ1, BIZ2, ANG1, ANG2, LSE1, FAM1, FAM2, WRK, PSYC, RC8, Dr1, Dr3, Dr4, Dr5, Hy3, Hy4, Pd4, Pd5, Sc1, Sc2, Sc3, Sc4, Sc5, Sc6, R, AAS, MDS.*

TREATMENT

The profile reflects an approach-avoidance conflict in relationships. Mood disorder and schizophrenia spectrum disorder should be ruled out. The 38 individual has a strong need for affection, yet fears others' hostility and abandonment. Consequently, therapy should proceed slowly, avoiding premature warmth from the therapist. Insight therapy can be disorganizing for the 38. Consequently, supportive and practical here-and-now orientations are most successful. The therapist should be aware of areas that the patient seeks to actively avoid, as this may be a source of their internal conflict. During the course of therapy, if the patient's associations become loose and they become distracted, this should be interpreted as a signal that they are feeling stressed by the therapeutic content. Drifting into religious or sexual themes during therapy may signal that the patient is anxious or experiencing emotions they perceive as potentially threatening. Once rapport has been established, explore childhood experiences of being frightened by an explosive or cruel parent. Rageful alcoholic outbursts or neglect directed at them or towards a loved one could have led to the adaptive response of shifting to internal distractions, away from the painful event. At the same time, the shift of focus away from reality could have resulted in poor reality testing under stress. Mindfulness therapy and dialectical behavior therapy can be helpful for them to learn to identify their emotions and express them in a more modulated manner.

Treatment: Rule out mood disorder and schizophrenia-spectrum disorder. Benefits from structure and support. Resistant to insight and psychological approaches, but may also have great difficulty focusing in therapy. Evaluate for suicide potential/precautions, neuropsychological impairment and biological treatments. Treatment plans initially focused on relief of psychotic symptoms, depression, anxiety, and problems such as disturbed sleep more effective than those targeting problems related to family, sexual identity, dependency, and so forth.

- Frequent diagnoses: somatoform or dissociative disorders (when 3 is relatively higher than 8, and 8 and/or *F* is less than 70), possible schizophrenia (when 8 and *F* both highly elevated). (Groth-Marnat, 2009)

Treatment Implications

Because they are typically apathetic and uninvolved in life activities, it is similarly difficult to engage them in therapy. Treatment is further complicated because their level of insight is low. Specifically, they place considerable effort into appearing normal despite considerable unusual underlying processes. Thus, individual insight-oriented therapy is contraindicated. However, they may be responsive to a more supportive and directive approach.

Therapy and Therapeutic Pitfalls

Clients with a 3-8 profile find insight therapy difficult and tend to resist it. Although unstructured insight-oriented therapy is contraindicated, they are helped by the structure of cognitive-behavioral therapy (Morrison, 2007). Close, trusting intimacy is frightening to them, but focusing on specific problem areas is less threatening. Open-ended questions by the therapist elicit cognitive slippage and disorganization, leading to conversations that meander and stray from the topic at hand. They will often drift into symbolic expressions of painful, conflicted impulses and desires, and encouraging such symbolic ventilation without verbalizing the interpretive meaning would allow clients relief without being overwhelmed by the vulnerability of exposure. Encourage discussion of dreams, writings, or paintings, and use art or music therapy to engage internal conflicts and anxieties (Chambala, 2008; Lyshak-Stelzer, Singer, St. John, & Chemtob, 2007). Supportive, noninterpretive, structured therapies work best. An increase in inappropriate behaviors or somatic symptoms may signify the onset of severe stress states. Rule out any neuropsychological problems as well as risk factors associated with a family history of psychosis or suicide. (Levak, Siegel, Nichols, & Stolberg, 2011)

Treatment and Self-Help Suggestions

1. Become aware that your conversations can drift away from the subject. What you're talking about might be making you anxious so you get interrupted and meander slightly off topic. Mindfulness training can help you experience thoughts and feelings in ways that are not overwhelming. Your therapist can help you practice various skills to develop mindfulness (e.g., being nonjudgmental, being mindful of one thing at a time, or focusing on your senses).¹ Practice being mindful of the moment without analyzing; simply watch the details in front of you without relating it to the past or future.
2. Recall with your therapist any moments in your life as a child where you were treated with coldness or hostility in a way that was upsetting and panicking. Recalling those events with the help of your therapist, learn to soothe your feelings, so that you know that you can calm down whenever you feel overwhelmed by emotions. With your therapist, practice self-soothing statements such as, "This won't destroy me," or "I don't have to experience this forever, but I can tolerate it for a few minutes." Other self-soothing techniques

include activities that bring you comfort such as listening to music, taking a walk, or cooking a favorite dish.

3. If you're comfortable with writing short stories or painting, this can be a way to communicate some of your feelings. Expressing yourself through art can take many forms: you can journal, collage, or use pencils, crayons, watercolors, or paints. Your therapist can help guide you in projects such as transformational self-portraits or drawing your dreams that will help you manage your feelings.²
4. Learn to recognize when you are angry, and practice assertiveness training with your therapist. Rehearse how to tell people what you want and how to tell them when you're angry so that you don't let negative emotions overwhelm you. Pay attention to your body because your physical symptoms likely increase when you are struggling with mixed feelings.³
5. Resilience building: Learning to assertively ask for what you want will do a great deal to help you manage overwhelming feelings and will give you a greater sense of self-control. Practice assertive requests with your therapist; role play situations where it is difficult for you to make requests. Assertive statements begin with "I" (e.g., I want; I feel; I think), "When you" (e.g., make jokes; don't help with housework; have me work late hours), and, "I would appreciate it if you would in the future" (e.g., not make jokes at my expense; do the dishes every other night; give me advance warning when you want me to work late).

¹ Experiential avoidance of emotions, thoughts, images, and memories can be useful at times but becomes problematic when it interferes with functioning and begins to distort perception (Adele & Feldman, 2004). Mindfulness training provides a way to nurture emotional balance and to change the habitual ways of reacting that obscure perception and judgment (Kabat-Zinn, 1994). Interest in mindfulness and its enhancement has flourished in recent years as evidence develops for the role of mindfulness in reducing psychological distress and enhancing positive mental health and emotional regulation (Coffey & Hartman, 2008; Goldin & Gross, 2010; Hargus, Crane, Barnhofer, & Williams, 2010).

² Carl Jung's theory that the verbal and visual contents of the artwork of his patients could give deep insight into the nature of their psyches laid the foundation for art therapy (McWhinnie, 1985). Art therapy has been shown to reduce symptom severity in both young and older adults with a variety of illnesses, including posttraumatic stress disorder, schizophrenia, bipolar disorder, major depression, and anxiety-related disorders (Chambala, 2008; Lyshak-Stelzer et al., 2007).

³ Subjects showed significant decrease in depressive symptoms after a 6-week assertiveness training program, and results were best maintained at 6-month follow-up with a group that received booster

sessions (Riedel, Fenwick, & Jillings, 1986).

(Levak, Siegel, Nichols, & Stolberg, 2011)

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you are a creative and sensitive person who dislikes conflict and confrontation. You can think in unconventional ways and find comfort in unusual philosophies. Sometimes, when stressed, you may experience periods of anxiety to such a degree that it is hard to think clearly. During stressful times you may find yourself unable to focus, with your mind easily interrupted by thoughts that seem disconnected from what you are doing or talking about. At times your mind may “run away with you” and you may drift into thoughts that may even be a little disturbing. During these stressful times it may be hard for you to concentrate, remember things, and organize your thoughts. Though you want closeness and connectedness with others, you are also somewhat fearful of it, perhaps concerned that the person you care about is going to hurt you or abandon you. People with your profile often grew up in an environment where a parent could be loving, but could also be angry or cruel in ways that were hard to predict and seemed odd. You may have learned to deal with them by escaping into your imagination, even as you tried to be understanding of their hurtful behavior. Perhaps you learned that you had to be strong, brave, and see what was positive about this difficult caretaker, even as they did things that hurt you. In some cases, parents like yours were alcoholics or had some other problem that made them act at times in a hurtful or neglectful manner. Now it is hard for you to deal with confrontation and conflict, and you seek comfort in philosophies that value love, sexuality, and caring. Though being sexual is important to you, it is also frightening because of your fear that you might get hurt again. Work with your therapist to understand how stress affects you. Whenever you are around people who are angry or potentially rejecting, watch how your conversation can drift away from the subject. Some anxiety-provoking situations can lead to your being interrupted by unwanted or odd thoughts, leading you to meander off the topic. Mindfulness training may help you experience thoughts and feelings in ways that are not overwhelming, and could help you stay on topic. Identify with your therapist moments in your childhood where you were treated with coldness, hostility, or cruelty in a way that was upsetting and even panicking. With the help of your therapist, learn to soothe some of your memories so that you can now calm yourself whenever you feel overwhelmed by emotions. If you’re comfortable writing stories or painting, this could be a way for you to communicate some of your feelings. Expressing yourself through art might include keeping a journal or making a collage. Learn to recognize when you are angry and practice assertiveness. Rehearse with your therapist how to tell people what you want in a clear, direct way.

Feedback Statements—Elevated Profiles (T-Score > 65)

Strengths

Your profile suggests that you have a number of strengths; you are a creative, perhaps artistic, and imaginative person. You generally work hard to avoid conflict and confrontation. You're not afraid to be different and perhaps even eccentric. You tend to have a rich inner world to which you sometimes try to escape during times of stress.

Bizarre Preoccupations

Sometimes, even when you're not stressed, you may find yourself involved in your inner world. Your thoughts may be quite creative; at other times, they may be unpleasant or violent. Because you want connection and closeness, you may also find yourself having a rich fantasy world relating to sexuality. Your sexual fantasies may be mixed with romantic images but also angry and distancing ones. This reflects your mixed feelings about closeness, wanting it but at the same time fearing it and even pushing people away for fear you may get hurt. People with your profile are quite preoccupied with religion. It provides a source of comfort and safety and some structure for your inner world. Sometimes your fantasy world may become so intense that you may have difficulty discerning whether it is real. These moments are likely frightening.

Somatic Symptoms or Forgetfulness

During periods of stress, you may experience a number of physical symptoms such as headaches, stomachaches, tingling and pain in the extremities, and even preoccupations with various parts of your body. In some cases, stress may get so severe that you actually have difficulties with your vision, hearing, and swallowing. You may also experience difficulties with your memory and concentration. As you try to organize what you're thinking and feeling, you may find yourself being interrupted by intrusive thoughts so that it's hard for you to remember the point you wanted to make.

Nonconfrontational

It is difficult for you to deal with any kind of conflict. Perhaps because of the way you grew up conflict was dangerous and people got hurt or were rejected when tempers flared. Now, if you're angry with someone, it may be hard for you to tell that person directly, perhaps out of fear that it will lead to a bad outcome. If you feel someone is angry with you, it might be quite scary, and you may find yourself developing numerous symptoms of stress.

Episodic Depression or Agitation

Sometimes, you may find yourself getting depressed, perhaps because it is so hard to think clearly and to maintain focus without a great deal of effort. During these depressed moods, you may feel apathetic, as if nothing can give you pleasure. At other times, you can get very excited, agitated, and wound up. Perhaps some religious or philosophical thought comes to you or some creative idea feels compelling, and then you can jump into action in somewhat intense and even disorganized ways. When something excites you, you may go off on a tangent without fully thinking through the consequences of your behavior.

Lifestyle and Background Feedback

Your profile reveals that you are knocked off balance by any conflict, confrontation, or anger from others. This could be the result of growing up with parents who were at times caring and nurturing but at other times cruel and rejecting. You were likely a sensitive child, and you wanted emotional closeness and connection. At the same time, it must have been disheartening to experience periods of coldness or some other kind of cruelty. You currently go through life wanting connection and closeness but being afraid of it. You've always been comfortable having a rich fantasy life, and perhaps one way you could escape painful moments was to retreat into your own inner world.

Normal-Range Feedback (T-score 50 to 65)

Your profile is within the normal range. It shows that you are a sensitive, creative person who probably has a good ability to fantasize. You are also a person who is susceptible to any kind of hostility or anger coming from others. You tend to avoid confrontations, and when faced with an angry or painful situation you may find yourself dealing with it somewhat obliquely rather than directly. You may also find that angry, confrontational situations interfere with your ability to think as clearly. Under stress, your natural ability to daydream and fantasize may interfere with your decision making. You may find that the richness of your fantasy world may sometimes interfere with your ability to think clearly. When faced with confrontation and anger, you likely try to stay positive and smiling, even when something painful is happening. In times of severe stress you may develop some physical symptoms such as headaches, backaches, or stomach upsets, which may be related to psychological stress.

(Levak, Siegel, Nichols, & Stolberg, 2011)

389 Code

Male

Low 0 One interview only, aggressive or belligerent, wants answers or insists on test scores, lacks knowledge or information, lacks academic motivation. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, shyness in the interview, lack of social skills,

mother conflict, being nonresponsive or nonverbal, being nonverbal or a nonrelator, being unrealistic or illogical, nervousness, restlessness, indecisiveness, unhappiness.

Low 1/2/4/5 Lacks knowledge or information.

Low 6 Lacks knowledge or information, rationalizes a great deal.

Low 7 Lacks knowledge or information.

Nothing Low Indecisive, unhappy, worries a great deal, confused, insomnia, lacks knowledge or information.

- Note: Scale 9 coded high was infrequently associated with indecisiveness and worrying a great deal.

Female

Low 0 Verbal, 8+ conferences, resistant in the interview, marriage oriented, tense on examinations, lacks academic drive, socially extroverted, confused, restless.

- Note: Scale coded low was infrequently associated with confusion.

Low 1 Verbal, resistant in the interview, 8+ conferences, marriage oriented, vague goals, socially extroverted, confused, restless.

Low 2 Verbal, 8+ conferences, resistant in the interview, marriage oriented, socially extroverted, confused, restless, exhaustion.

- Note: Scale 2 coded low was infrequently associated with confusion.

Low 4 Verbal, 8+ conferences, resistant in the interview, nonresponsive, marriage oriented, socially extroverted, shy in the interview, confused, restless.

Low 5 Verbal, 8+ conferences, resistant in the interview, wants answers, marriage oriented, distractible in study, socially extroverted, confused, restless, headaches, insomnia, exhaustion, anxieties, family conflict.

- Note: Scale 5 coded low was infrequently associated with resistance in the interview.

Low 6/7 Verbal, 8+ conferences, resistant in the interview, marriage oriented, socially extroverted, confused, restless.

Nothing Low Verbal, 8+ conferences, resistant in the interview, marriage oriented, tense on examinations, socially extroverted, lacks skills with the opposite sex, confused, restless, depressed, father conflict, mother conflict, sibling

conflict.

39/93 Codes

Code-Type 3-9/9-3

(Levak, Siegel, Nichols, & Stolberg, 2011)

Therapist's Notes

In the normal range the 3-9 individuals are energetic and gregarious with a “sunny” disposition. They are often seen as cheerful, pleasant, charismatic, and optimistic, and they enjoy challenge and excitement. They tend to repress and deny negative emotions and show occasional abrupt irritability if they feel controlled or if people frustrate their goal-seeking behavior. They work in spurts of high energy, are opinionated, and subtly extol their own virtues. They like to be the center of attention and gravitate to leadership roles. Individuals with elevated 3-9 profiles are ambitious, talkative, intense, opinionated, and socially fluent. These clients are performers or pleasers who unconsciously crave reassurance and approval. They tend to dominate conversations, frequently interrupt, and are dogmatic and opinionated. The 3-9 profile reflects a hypomanic drive for recognition, approval, love, and admiration from others.

Descriptors

Complaints

Driven, talkative, occasionally explosive, hypomanic, possibly alcoholic, possible neurological problems, may be combative, somatic and physical complaints, judgmental, perfectionist

Thoughts

Competitive aggressive, optimistic, unrealistic, grandiose, excitable, ambitious, critical, lacking in insight, boastful

Emotions

Denying, repressing, labile, exuberant, excitable, panic attacks, strong needs for approval

Traits and Behaviors

Gregarious, outgoing, socially surgent, dramatic, self-centered, charismatic, extremely driven, needing of reassurance and approval, labile, somatic under stress

Often conversations are centered on their achievements, opinions, and goals. Although they can be entertaining, interesting, and verbal, they tend to switch topics often to maintain the center of attention, to keep control, and to keep the focus away from anxiety-laden topics. They are highly competitive, reflecting their fear that approval is a zero-sum game. For the 3-9 code types, the world is hierarchical, and people are worthy of approval only if they are the “best.” Denial, repression, inhibition, and a lack of insight characterize this profile type. Although generally upbeat and sunny, they can quickly become irritable and angry, especially when frustrated or if they perceive that someone is attempting to control them. Other competitive individuals irritate them. Often they will argue a perspective, not because of a firm belief but because it allows them the stage. At times they can be explosive, with brief, episodic, angry outbursts followed by a denial of the seriousness of the event. In some cases, this profile has been associated with brain trauma, and in the presence of any soft signs this should be further evaluated. Often, the MacAndrew Alcoholism Scale-Revised (MAC-R) is elevated, reflecting their vulnerability to alcohol and chemical abuse. They may use substances as a way of controlling their hypomanic energy. The 3-9 code types are highly demanding and perfectionist. They tend not to give approval easily. As spouses, bosses, and parents, they expect perfection as a starting point and are quick to point out others’ failings, reflecting their own competitiveness. Their

hostility and criticism can be expressed in a roundabout, sarcastic, joking manner, but they typically deny hostile feelings. In some cases, especially when under the influence of chemical agents, they can be verbally and even physically assaultive. They are often unaware of their self-centered and angry impulses. When stressed, they move into action and become overcommitted, excitable, and demanding. They have difficulty saying no and tend to be opportunistic because of their drive for success and fears of failure. Emotionally overcontrolled and distracting themselves with overactivity, they are vulnerable to episodic anxiety attacks, which reflect the buildup of conflicts and unresolved emotions that tend to be expressed as a somatic complaint or a specific fear or phobia. These individuals can be quite demanding and overbearing, easily taking the center of attention and sulking if they lose it. (Levak, Siegel, Nichols, & Stolberg, 2011)

Lifestyle and Family Background

Our hypothesis is that 3-9 persons were raised on a partial reinforcement schedule of approval and recognition. Often, they were energetic, if not hyperactive, children and had parents who were controlling, demanding, critical, and only intermittently approving. They learned that love was dependent on achievement and success. They were often praised for their performance, and some were asked to perform their particular skill in front of family and friends. Their essential conflict is between a strong need for love, approval, and success on one hand and their fear of control from those who may provide it on the other. The 3-9 code types are sensitive to criticism and can quickly become argumentative and angry if they feel disapproval.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Energetic, gregarious, socially outgoing, and self-assured, these individuals are also surgent, aggressive, stimulation seeking, flattering, and garrulous. They tend to be socially assertive and can be quite entertaining for brief periods of time, but can be seen as too self-centered and dominant. They are driven, ambitious, highly active individuals. They often switch discussion topics, especially when exploring an anxiety-loaded one, and they defensively extol their own virtues. They are competitive and often argue a point for the sake of being right, rather than out of a firmly held belief. Denial as a defense is associated with both Scale 3 and Scale 9. Scale 3 predicts overcontrolled “niceness” and strong needs for approval. Scale 9 also predicts needs for approval and to be the center of attention. Taken together, the 93 codetype reflects an individual who feels intense need for constant approval. Anger tends to be overcontrolled, with sudden breakthroughs of strong feeling. Such explosive episodes are usually targeted at a specific person in their environment. Usually the anger is directed at anyone trying to control or criticize them, or provide them with reality testing in response to some of their colorful exaggerations. They are described as perfectionistic, demanding and, at times, explosive, even assaultive. Repression and denial are typical defenses.

These individuals are quite excitable, but they are also vulnerable to episodic anxiety and panic attacks as repressed emotions break through their overcontrol. During times of stress, somatic complaints such as cardiac symptoms, headaches, and gastrointestinal problems reveal their high level of internal tension. They are often quite concerned about these somatic symptoms, partly because they fear that the symptoms will restrict their overactivity. If Scale 1 is elevated, somatic complaints are predominant. These, in particular, respond well to treatment, combined with reassurance. Often the *MAC-R* is elevated, so addiction proneness is likely. The 93 individual takes leadership roles and is quick to take on a cause, which provides an outlet for their energy, ambition, and needs for social prominence. As parents, they tend to be controlling and have difficulty accepting values different from their own. They are highly critical and hold others to a high standard. They lack insight and are quite argumentative when confronted with their behavior. Childhood histories suggest strong needs to prove themselves, sometimes because of parents who were controlling and demanding. Some learned that performing for praise was the way to obtain love and continue to do so. They can be demanding and exhausting spouses.

o Moderate emotional and behavioral undercontrol with overtalkativeness, angry volatility, social aggressiveness and stimulation seeking, and strong avoidance of anxiety and internal discomfort. Affectively buoyant and excitable, but vulnerable to anxiety and panic attacks. May feel driven, especially to distract self from negative emotionality. Somatic complaints may include cardiac symptoms, chest pain, tachycardia, and the like. Socially skilled, smooth, and self-assured, with strong needs for recognition, approval, and admiration. Seeks social stimulation, but tends to be considered self-centered, demanding, overbearing, boastful, conceited, and insensitive. Unstable emotional and behavioral controls; may be verbally hostile or even assaultive when frustrated or slighted. Narcissistic. Holds others to high standards and may be critical with intimates. Rigidly denying; impervious to insight. Look for history of mood disorder and parental domination; current marital discord.

1. These people may be dramatic, superficially open, and highly visible in social situations (Hovey & Lewis, 1967).
2. They may have episodic attacks of acute distress (Dahlstrom et al., 1972; Guthrie, 1949; Hovey & Lewis, 1967).
3. The physical problems of this group usually are not severe and tend to be easily treated (Hovey & Lewis, 1967). They may develop medically atypical or medically impossible symptoms which yield to superficial treatment.
4. Kelley and King (1979a) found the 3-9/9-3 profile code in a college counseling center. Female clients typically had come in because of difficulty with an instructor (to whom some of them were sexually

attracted). They were seen by their counselors as defensive and were diagnosed frequently as hysterical in spite of having depression and disturbed thought processes. These women seemed to be in acute distress precipitated by the interpersonal conflict with their instructors.

Medical patients with a 39 pattern in Guthrie's study presented histories of episodic attacks of acute distress. The attacks were marked by anxiety, palpitations, and tachycardia. The presenting complaints of 39 patients seemed to center about the lower gastrointestinal tract, the back, and the extremities. When they had intestinal cramps or headaches, the pains came on suddenly and intensely. On the other hand, ulcers, hypertension, and respiratory difficulties were virtually absent. Occasionally the medical problems showed a classic hysterical pattern, being both dramatic and medically atypical or impossible. The 39 patients were frequently described as aggressive and as directing considerable hostility toward a domineering mother. While none of these patients had periods of severe depression in their histories, most of them were depressed and fatigued at the time they were seen. The physical problems of this group were not of a severe nature and readily yielded to superficial treatment. (Dahlstrom, Welsh, & Dahlstrom, 1979)

Description:

Mostly females, extroverted, dramatic, attention seeking, aggressive, easily distort own perceptions, sexual problems, somatic complaints

Possible Diagnoses:

Somatization, Bipolar, Conversion, Explosive p.d., Psychosis, Histrionic, Panic, passive-aggressive

Modifying Scales

- o When Scale 1 is elevated, look for numerous physical symptoms associated with stress and tension. Physical symptoms may shift and change in a manner similar to the 1-3 profile. Clients may show a blind indifference to these symptoms, while, at the same time, demanding affection and attention because of them.
- o When Scale 4 is elevated, look for sporadic and impulsive breakthroughs of self-indulgent and even antisocial acts. The 3-9-4 code types are individuals who may be socially prominent and appear conforming and appropriate but may have a secret life with occasional acting out that is effectively hidden, especially if the K scale is also elevated. The 3-9 profiles with a low Scale 4 (T-

score 50 and below) are moralistically judgmental individuals with strict values.

- o When Scale 6 is coded third, look for more brittle, angry, and rationalized outbursts and a tendency toward punishing vindictiveness.
- o When Scale 8 is coded third, these clients may have schizoid or manic periods with potential brief psychotic episodes or cognitive slippage.
- o When Authority Conflict (Pd2) is highly elevated, this increases the likelihood of antisocial acting out, which is disguised and covered over by social appropriateness.
- o When Naïveté (Pa3) is elevated, this would add to the rigidity and self-righteousness already associated with the 3-9 profile.
- o When Antisocial Practices (ASP) is elevated, this would increase the likelihood of leading a double life, especially if Scale 4 is coded third.
- o When Anger (ANG) is elevated, especially if OH is also elevated, then the angry outbursts may be dangerous.
- o Interestingly, Type A Behavior (TPA) is typically not elevated in this profile. Impatience, irritability, and needs to vanquish opponents are associated with Scales 9 and 3, but this does not seem to elevate TPA.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Male

Low 0 One interview only, aggressive or belligerent, wants answers or insists on test scores. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, shyness in the interview, lack of social skills, mother conflict, being nonresponsive or nonverbal, being nonverbal or a nonrelator, being unrealistic or illogical, nervousness, restlessness, indecisiveness, unhappiness.

Low 6 Rationalizes a great deal.

Female

Low 0 Marriage oriented, tense on examinations, lacks academic drive, socially extroverted, verbal.

Low 1 Marriage oriented, vague goals, socially extroverted.

Low 2 Marriage oriented, socially extroverted.

Low 4 Marriage oriented, socially extroverted, shy in the interview, nonresponsive.

- Note: Scale 9 coded high was infrequently associated with shyness in the interview.

Low 5 Marriage oriented, distractible in study, socially extroverted, verbal, headaches, insomnia, exhaustion, home conflict.

Low 6/7/8 Marriage oriented, socially extroverted.

Nothing Low Marriage oriented, tense on examinations, socially extroverted, verbal, mother conflict, father conflict.
(Drake & Oetting, 1959)

o **Check:** *ANX, HEA1, HEA2, HEA3, BIZ1, BIZ2, ANG1, ANG2, LSE1* (low), *LSE2* (low), *SOD1, SOD2* (low), *AMI, FAM2, AGGR, DISC, PSYC, D4, Hy3, Hy4, Sc5, Sc6, Ma1, Ma2, Ma3, Ma4, Si1* (low), *Si2, R* (low), *MAC-R, AAS, MDS*.

TREATMENT

In some cases this profile reflects a mood disorder. Though rare, it can also be associated with an organic brain disorder. In the absence of recent brain trauma or a mood disorder, the profile suggests a hypomanic individual who shows conflict between needs for self-assertion and needs for approval. A childhood history of caregivers who were constantly pushing for performance and achievement is typical. Help the 93 patients to develop their own goals, rather than internalized parental expectations. Help them understand how their strong needs to perform and achieve are understandable, given that approval was often dependent upon performance in their histories. Mindfulness therapy would help them identify when anger is building and learn non-impulsive ways to express it. Also help them understand how they argue instinctively, perhaps as a response to a lack of validating childhood experiences.

The 93 individual tends to experience anxiety episodically, usually around a perceived achievement failure.

Consequently, they lack persistence in therapy and are easily distracted and bored. In therapy or when stressed they may appear boastful, both eliciting flattery by flattering others, and at the same time extolling their own virtues in order to gain approval. This behavior replicates their relationship with their caregivers. Rapport can develop if the therapist can find genuine ways to be approving of the positive attributes of the 93 codetype. 93 individuals need to develop a way to reward themselves for their achievements, rather than working hard for others' approval, which leaves them feeling controlled.

Treatment: Rule out mood disorder. Lack of distress and narcissism-based denial limits engagement with psychotherapy; diverts attention from problems to positive traits, acts, or achievements. Somatization may respond to reassurance. Focus on presenting problems and seek to provide symptomatic relief.

Therapy and Therapeutic Pitfalls

These clients tend to quickly project onto the therapist the role of disapproving parent. They tend to dominate the therapeutic conversation, preemptively defending themselves, extolling their virtues, and initially flattering the therapist. The flattery tends to be subtly hostile, such as, “Well, you’re the doctor, and you know so much more than I do.” They are competitive and quickly argumentative if they feel criticized. A therapeutic alliance can be built by giving feedback to the clients about their positive attributes. Focus on their high energy, their drive, their need to please, and their ambition. Define them as wanting to please, as hard working, and as needing to prove themselves to help them gain insight into their inner drives. Engage childhood feelings of striving for love and approval to help them develop empathy for themselves. Help them distinguish what they want for themselves as opposed to internalized parental values and goals. They approach life in a hypomanic, driven, impatient, and irritable way, always in a hurry for the next step. Help them understand their sense of urgency, and realize that it is fueled by a need to continually prove themselves. Mindfulness exercises such as spending the day focusing on the present can help them identify their sense of urgency and irritability (Zylowska et al., 2008). Consider approaching them from a coaching rather than a therapeutic perspective. The goal of therapy is to help them manage their energy and impatience, avoid overcommitting, and develop insight into how they have been driven to associate success and achievement with love. Also, teach them to be more generous in giving others approval rather than repeating their parents partial reinforcement schedule.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Treatment and Self-Help Suggestions

1. Acknowledge that you have more energy and drive than most people and that, while this can help you be successful, you have to manage your energy so that you don’t overcommit and become scattered and unfocused. The practice of mindfulness is a way for you to channel your energy and to increase your focus and productivity. Mindfulness involves paying attention to the present moment in a nonjudgmental way and to foster a quality of curiosity and openness. For more information on mindfulness exercises see www.mindfulnessstapes.com. You can begin by setting aside time to watch the moment without analyzing

or judging it. Pay attention to the sight, sound, taste, smell, and feel of the experience. Engaging in a daily practice of mindfulness can help you redirect your attention instead of going on autopilot.¹

2. Learn to meditate for a short time period every day so you can slow down or even stop your constant stream of thoughts. There are many types of meditation practices, but all of them have been demonstrated to help control distracting thoughts and to improve concentration and focus. One simple meditation technique involves sitting comfortably for 10 to 15 minutes each day with your eyes closed and silently repeating a sound, word, or phrase (called a mantra) to calm the mind and body. Overall, the regular practice of meditation is linked with many long-term positive effects such as increased positive emotions, focused attention, and emotional stability.²
3. Watch your tendency to be overly optimistic, to overcommit, and to promise people things that you may have a tough time delivering. In the moment, everything seems possible, so it's easy to commit to people, but then later you may find it hard to follow through. Some basic strategies can help you manage your tendency to take on too much. Buy some time with the phrase, "Let me check my calendar," to postpone making decisions until you've fully thought through the situation. Use calendars and daily reminders, and make daily lists of things to do so you can track your priorities and have a better idea about what you can fit in. Think and plan ahead to avoid taking action prematurely.
4. Be mindful that your high energy can make you irritable, impatient, sarcastic, and verbally cutting. After you get angry, the effects of your anger may well linger with other people even though, for you, the situation passes quickly and you forget about it.
5. Find ways to control your temper. When you notice tension building and when you catch yourself being sarcastic or verbally cutting, take a step back and find ways to manage your intensity and anger. See if you can identify any cognitive distortions that are triggering your anger. Because you work so hard to excel, your perfectionism may trigger your anger with "all-or-nothing" thinking (i.e., I'm either perfect or worthless). Realize that because we all have human limitations, this is a no-win situation. Work with your therapist to explore where these ideas came from, and then to develop some alternate ways of thinking that will help you manage your anger.³
6. Work with your therapist to determine what it is you want in life versus the goals and standards you may have taken on from your parents.

7. Try to avoid chemical agents as a way of fine-tuning your high energy. Be aware of that chemical agents can aggravate your mood swings. Eat a healthy diet, get regular exercise, and stay away from overstimulating environments. If you still find it difficult to manage your energy and mood, consult with your doctor about medications that may help.
8. Watch your tendency to interrupt other people; instead, take a deep breath, step back, and focus on whether you truly have something to say or whether you feel anxious. Change your habit by increasing your listening skills. This will help you convey greater request in others. Develop an interest in the other person, and focus on what the other person is trying to communicate rather than trying to make your own point. You will actually have a greater chance of being persuasive and having your ideas accepted if the other person feels heard and understood.

¹ Researchers have debated about using mindfulness for hyperactivity and distraction for some time; there was a question about whether individuals with impulsivity and hyperactivity could actually engage in mindfulness meditation exercises. Zylowska et al. (2008) conducted an 8-week mindfulness-training program for adults and adolescents with attention deficit hyperactivity disorder (ADHD). Subjects reported improvement in ADHD symptoms and also had better test performance on measures of attention and impulsivity.

² Neuropsychological studies examining the effects of both short- and long-term meditation using magnetic resonance imaging (MRI) have found great promise in the positive effects of meditation on cognitive structures and processes. Although empirical studies of meditation are still in a stage of infancy, research is linking improvements in both psychological and physiological well-being to meditation (Luders, Toga, Lepore, & Galer, 2009). Neuropsychological studies of meditation find functional and structural improvements in areas of the brain that involve attentional circuitry, automated reactivity, attentional engagement, focused cognitive processes, and task discrimination processing (Cahn & Polich, 2009; Lykins & Baer, 2009).

³ It may help to explain the “ABC” concept of rational emotive therapy (Ellis & Dryden, 1997) where an event (A) leads to a thought (B), which then leads to an emotion (C), so that although clients feel as if the situation is making them angry it is actually their interpretation of the event that leads to their negative feeling.

(Levak, Siegel, Nichols, & Stolberg, 2011)

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you are extremely energetic, driven, and ambitious. You tend to have two speeds in life, full speed and off. You may find yourself impatient with a world that moves more slowly than you do. You tend to

think and move quickly, and you have a tendency to overcommit. Be careful not to confuse activity with productivity. Because of your high and often positive energy, you often see the world as full of possibilities. However, this may lead you to overcommitting and becoming distracted, not always finishing the tasks you begin. Perhaps, growing up, your parents were always motivating you by reminding you that you can do more and better. Perhaps you received praise and love for performing. You've probably always had high energy and you've probably always been competitive and driven. Your parents' tendency to try to control you, always pushing you to succeed more, has likely instilled in you a need to constantly be productive and to let people know of your success and achievements. You may find yourself becoming easily involved in arguments, especially if someone comes across strongly, perhaps because it reminds you unconsciously of a controlling parent and not being heard. You may feel a need to resist when people are pushy or bossy. Though you are generally positive and optimistic, you can become quite upset and despondent if you feel you are failing at something. You have very high standards, so others may feel that you are critical and demanding of them, perhaps in the same way that your parents were. When stress is accumulating, you may occasionally experience periods of anxiety, physical symptoms, and increased irritability. These might be quite frightening to you. You may use chemical agents such as alcohol as a way to try to control your high energy level, but this may backfire. Be careful that you do not overdo it, and that chemical agents do not aggravate your irritability or explosiveness. Learn to recognize when frustration and stress are building so that you can express these feelings without blowing up. Acknowledge that you have more energy than most, but also be aware that, to be successful, you have to manage your energy so you do not overcommit and become scattered and unfocused. Mindfulness training could help you by teaching you how to pay attention to the present moment in a nonjudgmental way. You do not always have to correct others, even when you are right. Learn to meditate daily so you can slow down and manage your need for constant activity. Watch your tendency to be overly optimistic and to impulsively overcommit. Your natural optimism may make you feel all things are possible, and you have a tendency to take on too much. Buy some time with the phrase, "let me check my calendar," before making a decision about a commitment until you've fully thought it through. Be mindful that your high energy can make you feel irritable, impatient, sarcastic, and verbally cutting because people are not as quick as you are. Even though you forget about your blowups quickly, others may remember them longer. Work with your therapist to determine what you want in life versus the goals and standards you think you should have. Watch your tendency to interrupt people as they talk. Whenever you feel like interrupting someone in a conversation to "correct him," take a deep breath, step back and focus on whether correcting him will be productive.

Feedback Statements—Elevated Profiles (T-Score > 65)

Strengths

Your profile shows that you have a number of strengths. You are an energetic, driven, ambitious individual who can be sunny, positive, and even charismatic. People with your profile are comfortable taking charge, being leaders, and being in front of people. You're not afraid to state your opinion.

Ambitious or Competitive

You are highly ambitious, and it is important for you to be successful. You are competitive, and you drive yourself to do better and better. In fact, it's hard for you to say no to people, and you sometimes overcommit yourself to too many tasks and activities.

Energetic and Optimistic

Your energy level is higher than most people's. It appears you have two switches: full speed ahead and off. From the time you get up in the morning, your mind is racing. You're either thinking very quickly or doing many tasks and activities, sometimes multitasking to the point of overload. Generally, you are a sunny, positive, and optimistic person. You have a lot of faith in your own ideas and opinions, and you're not afraid to push forward with what you think is right. You're probably a big picture thinker and somewhat impatient with having to take care of the small details.

Explosive

Although generally upbeat and positive, you can quickly become irritable, angry, and even verbally explosive if you feel people get in your way when you are on a mission or if they slow you from doing what you want. You have strong opinions, and you can become quite angry if people try to control you or tell you what to do. When you blow up, you seem to get over it quickly, and the event passes almost as if it never happened.

Hypomaniac

Although you love approval and people's admiration, when people praise you it is hard for you to let yourself fully appreciate it. It's almost as if approval and success make you feel driven to do even more. It's hard for you to be in the moment and to relax and enjoy what's happening around you because you're pushing yourself toward the next accomplishment and success. These high levels of energy can make you exciting and fun to be around but can also make you somewhat scattered, and overcommitted, with occasional difficulty in completing all the things you commit to.

Extroverted or Talkative

Your high energy may also make you quite talkative and socially prominent. You enjoy being the center of attention, and you like to tell people about your accomplishments. Competitive people engage your competitive side and can irritate you if they don't acknowledge your strengths. You are social and extroverted, and you make a good first impression. Being around other people who are dominating or talkative can lead you into verbal conflicts and arguments because you like to be in control of the conversation.

Somatic or Sometimes Alcoholic

Sometimes people with your profile develop physical symptoms of stress. With all your high drive and energy and your need for approval, love, and attention, you may experience physical symptoms of anxiety. Sometimes people with your profile use chemical agents, such as alcohol, in an attempt to manage their high levels of energy.

Critical or Perfectionist

You are driven, and you tend to be your own worst critic. Others may see you as perfectionist and critical of them because perfection is a starting point for you. People close to you may feel that it is hard to get your approval and that you're always subtly and not so subtly pointing out how they can do better.

Excitable or Labile

When you have so much energy, you may find your mind racing, persistently interrupted by new thoughts so that it is hard to keep a stream of thought and stay focused. It's almost as if your accelerator is always pressed to the floor but your brakes are on because you don't want to come across as greedy, impatient, demanding, and irritable. You may experience a push or pull feeling, wanting to be first but not wanting to be disapproved of. You may end up overcommitting on tasks and activities and perhaps being a little reckless in spending or taking on tasks. Any kind of failure is extremely painful for you, and you become fearful that you will lose others' love and approval.

Lifestyle and Background Feedback

Growing up, you may have had parents who were quite controlling, perhaps loving but also quite demanding. They may have expected high levels of achievement and performance from you. Perhaps you were praised for a particular talent that gave your parents pride, or you may have felt that you had to carry the family honor and demonstrate great success and achievement. One of your parents likely pushed you so that no matter what you did nothing was ever quite perfect enough for you to stop, rest, and enjoy your successes. You have always been driven to succeed, to achieve, and to prove yourself. It's as if you're going through life determined to show that you are worthwhile, that you can accomplish great things, and that you are deserving of love and approval.

Normal-Range Feedback (T-score 50 to 65)

Your profile is within the normal range and indicates somebody with an energetic, “sunny” disposition. You are probably comfortable being the center of attention, and you are able to command it. When excited, you may see all the connections among things and may switch topics frequently. You enjoy pleasing people, and it is rewarding for you to have people around you be happy with you. You are generally easygoing and friendly, but occasionally the world may move a little too slowly for you, which may make you impatient and irritable. You generally demand excellence from yourself and those around you. Occasionally, you may be insensitive to the fact that not everyone has your energetic and optimistic personality. People may see you as unrealistic and demanding. When goals have become frustrating or boring to you, you may change professions, careers, or goals, although probably in a way that generally benefits your progress.

(Levak, Siegel, Nichols, & Stolberg, 2011)

30/03 Codes

This relatively unusual code may appear contradictory in that Scale 3 suggests needs for social connection and approval, whereas Scale 0 elevations suggest social withdrawal or avoidance. Taken together, the two scales suggest a passive, dependent, unassertive, and somewhat withdrawn individual who is unassumingly “nice,” but quiet. Stress may lead to episodic psychosomatic complaints, and this often is reflected in Scales 1 and 2, which frequently are the next most elevated scales. These individuals appear relatively comfortable with their level of adjustment. Their primary defenses are repression and denial.

TREATMENT

Because these individuals tend not to experience much psychological or emotional distress, they rarely seek treatment. Anxiety, although not uncommon, tends to be transitory. Social skill building, anger recognition, and assertiveness training are suggested foci of therapy. Look for childhood experiences of hostility or other emotionally

painful events that have led them to feeling apprehensive, to “shut down” emotions and to be “brave” in the face of pain. In long-term therapy cases, help them re-experience any past frightening or painful events and learn to vent the appropriate anger around those events to unblock repressed anger and sadness.

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you are a somewhat shy individual, comfortable with small groups of familiar people. You generally avoid conflict, and try to see situations in a positive light. Consequently, when you eventually do feel irritated or angry, it may come out more sharply than you realize. At other times, your tendency to avoid conflict and

make a fuss may lead to physical symptoms of stress such as headaches, stomach upsets, low back pain, or other episodic physical symptoms. You may have experienced physical illness or other emotionally painful or frightening events that led to the adaptive response of being brave and repressing uncomfortable feelings. Social shyness is probably an inherited trait and will only cause distress if you are in a situation where you have to socialize and be more socially assertive than you enjoy. In such cases, you may apply social skill-building techniques and perhaps learn to identify when negative emotions are building so you can express them directly. Explore with your therapist any painful memories where you had to be brave and not upset people you cared about.

Scale 4: Psychopathic Deviate (Pd)

Descriptors

Complaints

Conflicts with authority figures, rule breaking, difficulty with intimacy, acting out, alcohol or drug abuse potential, impulsive behavior, manipulative, narcissistic, rebellious, angry

Thoughts

Mistrustful, alienated, angry, restless, bored, Machiavellian, calculating, immediate self-gratification

Emotions

Insensitive, impulsive, socially intrepid, shallow, superficial, blaming, stimulation seeking, restless, bored, emotionally disconnected

Traits and Behaviors

Superficially charming, immature, self-absorbed, impulsive, unreliable, irresponsible, adventurous, assertive, enterprising, manipulative, demanding, lacking discipline and judgment

(Levak, Siegel, Nichols, & Stolberg, 2011)

Therapist's Notes

In the normal range, Scale 4 predicts individuals who are independent and self-sufficient; they like excitement, novelty, and challenge. They can be superficially friendly, even charming, but they have difficulties with long-term emotional trust and intimacy. They feel most comfortable in unstructured situations where others' control over them is limited, though they tend to be impulsive without structure. Scale 4 is a heterogeneous scale measuring a number of different personality dimensions. It is a mistake to assume that all persons with high Scale 4 scores are necessarily antisocial or act out aggressively. Individuals going through difficult life transitions such as divorce, job loss, or interpersonal conflicts sometimes obtain elevations on Scale 4. In response to stress, they may emotionally

numb themselves as a way of protecting against feeling vulnerable. If these individuals have experienced recent, severe stresses, and do not have a history of antisocial or hedonistic self-indulgence, Scale 4 elevations may reflect a temporary protective shutdown of empathy and emotional involvement. Generally however, individuals with this profile have difficulties with authority figures, and are uncomfortable with the vulnerability associated with emotional intimacy. Their relationships tend to be shallow, and they are often exploitive of others. High Scale 4 individuals can be manipulative and lacking in empathy. They have difficulty postponing gratification and act out in various ways. They lack discipline and tend to give in to impulses without regard for long-term consequences. It is important to determine whether high Scale 4 is characterological or whether it reflects a situational adjustment. Given a history of interpersonal difficulties and subtle or overt acting out, the profile may reflect a character disorder rather than a recent adjustment problem. It is also important to consider the profile in the context of cultural milieu and socioeconomic status. For example, a Spike 4 profile obtained by the head of a university department may reveal a ruthless Machiavellian, self-centered, highly politicized management style but not necessarily someone who has conflicts with authority. High-level executives who are reckless, take unnecessary risks for their own gain, and manipulate the system could reflect upper socioeconomic status (SES) Spike 4 types. Such individuals are unlikely to be in trouble with the law, unless it is for white-collar crimes, but their manipulation, lack of empathy, and tendency to bend rules for their own benefit can cause interpersonal turmoil, conflict, and even systemic economic risks. Based on a high 4 elevation, a psychologist may be tempted to predict antisocial behavior, but in the context of cultural milieu, and perhaps tempered by socioeconomic and educational variables, the manipulations and narcissism associated with Scale 4 can be moderated and kept in check so that legal consequences are avoided. A history of acting out, rebellious behavior, interpersonal difficulties, and self-defeating acts would suggest that the Scale 4 elevation is predicting continued acting out behavior.

These individuals are rebellious and instinctively resist being controlled. Some can be charming and gregarious, especially if Scale 0 is low. In other cases, they can appear cold and aloof, keeping their emotional cards close to their vest until they feel they have control. Most individuals with an elevated Scale 4 tend to see the world as a dog-eat-dog place where they need to exert power over others to avoid it exerted over them. In some cases, they run into legal difficulties because of poor judgment or poorly controlled impulses. Long-lasting intimate relationships are difficult for them, not only because they dislike being vulnerable but also because they are self-focused. They tend to selectively report, if not overtly lie, to achieve their goals, reflecting their belief that getting their way requires manipulation and deviousness. They show a low tolerance for frustration and an inability to delay gratification. There appear to be a number of clusters within the Scale 4 genotype (Astin, 1959; Comrey, 1958). Sometimes a high Scale 4 reflects hedonistic, disorganized, live-in-the-moment, freewheeling individuals who show poor impulse control. Another cluster is more Machiavellian and organized; their self-centered goals are ruthlessly pursued but

with a degree of calculated discipline. This would be particularly true if the Correction (K) scale and Ego Strength (Es) are also elevated. A third cluster of individuals are charming, hedonistic, impulsive types whose temper and dangerous aggressiveness can be set off by frustration and aggravated by alcohol and drug use. Sexual promiscuity, drinking, fighting, and trouble with the law would characterize these types. A fourth group is passive, dependent, self-indulgent, and undisciplined; Alex Caldwell described these individuals as similar to the 1960s cartoon character Andy Capp: abusing alcohol and badgered yet supported and nurtured by a codependent wife (Personal communication, April 1985).

Sometimes, high 4 individuals complain of depression. Because the original criterion group consisted of court-referred juvenile delinquents primarily diagnosed as having psychopathic personalities (Hathaway & McKinley, 1943), a number of the Scale 4 items reflect despondency, feelings of defeat, and a sense of self-pity. This is usually associated with a current situation that resulted from poor judgment and self-defeating behavior. Blame is usually externalized; the depression involves less sadness and more glum despondency and self-pity. Sometimes guilt is used manipulatively to engender sympathy or forgiveness for recent acting-out. (Levak, Siegel, Nichols, & Stolberg, 2011)

Lifestyle and Family Background

The Spike 4 individuals' lifestyle is that of self-serving, manipulative dependency, and impulsive tension reduction. Childhoods in which parents were controlling and arbitrary but also indulgent would be typical. In other cases, the emotional under-arousal associated with Scale 4 elevations is related to both a genetic predisposition and emotional numbing in response to parental abuse, neglect, or self-absorption. As children, they often exhibit rebelliousness and difficulties with peers and teachers. As adults, they have shallow relationships with a low capacity for empathy. They tend to manipulate others into taking care of them, and when their impulsiveness leads to difficulties they externalize blame rather than taking responsibility. Their lifestyle is punctuated by periods of success, especially if they are capable and bright, but they will show episodic catastrophic failures as a result of poor judgment and lack of discipline.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Spike 4 occurs when Scale 4 is the only scale above *T*-65 (or when Scale 4 is 10 or more *T*-score points above all the other scales in an elevated profile). See above for associated traits. If Scale 0 is low (a *T*-score of 40 or below), their need for social interaction and their social ease allows them to make a good first impression, though others may sometimes see them as somewhat slick or glib.

A low tolerance for frustration, an inability to delay gratification, and a generally hedonistic approach to life are typical. Self-control is poor, and so conflicts with caregivers, family members, and authorities are common. If the *K* scale is above *T*-60, and if the individual is of above-average intelligence and education, these behaviors can be masked under a veneer of social correctness. Extramarital relations and unusual or atypical sexual histories are common. When a Spike 4 encounters negative consequences for their actions, they often experience transitory guilt and depression, which tends to be self-pitying, with little effect on corrective behavior change. In the absence of any history of acting out or deficits of conscience, the Scale 4 elevation in the presence of a situational stress may reflect “emotional numbing.” Psychotherapy in the latter case can uncover underlying blocked emotions and a second MMPI-2 testing may then reveal a different codetype. If there is a history of acting-out behavior, the Spike 4 is characterological. Childhood histories of parents who were either overindulgent and inconsistent, or emotionally unavailable, could have created the adaptive response of emotional numbing and the development of a “survivor” profile. Manipulativeness and deviousness would make sense as an adaptive response to a situation where the individual could not trust that their emotional needs would be consistently met. Often they exhibit conflicted marriages, though, surprisingly, not always ending in divorce. Many marry individuals who are co-dependent and tolerate their acting-out behavior.

Spike 4 is predictive of addiction-proneness, particularly if the *MAC-R* scale is elevated. They tend to externalize their problems and selectively report, even in therapy.

o Underdeveloped behavioral controls and emotional instability, with acting out, irresponsibility, social and interpersonal aggression, impulsivity, intolerance of frustration, and substance abuse. Judgment is often poor and sometimes reckless. Occult dysphoria and a lack of meaning and satisfaction in life are common. Good social skills, but selfish, self-centered, demanding, exploitive, and unreliable in relations with others. Appears unable to profit from punishing experience or to maintain progress toward long-term goals. Relationships evidence superficiality, absence of commitment, and high turnover. Intimidates with volatile temper. May be dependent in stable intimate relationships but often estranged from family. Rebellious toward rules, authority, and convention. Cynical; locates problems outside self. Sense of entitlement. Look for history of delinquency and adult antisocial conduct, job loss, fighting, substance abuse, and marital problems; recent loss of significant relationship.

Meehl (1951) has indicated that when scale 4 is the low point of the profile, the subjects appear to be characterized by a lack of heterosexual interest. Although this characteristic may appear in a variety of ways, the lack of effective expression of normal sexual interests seems pervasive. Other data on these cases are summarized in Cantor's (1952) dissertation.

Scale 4 appears prominently in many profiles from both normal and psychiatric populations. It is one of the frequent peak scores, particularly in males, and appears very often in a variety of high-point pairs. The preponderance of scale 4 elevations increases markedly in prison groups (see Appendix M), where the sex difference becomes negligible.

The usual sex difference is actually reversed in the data Sundberg (1952) collected on outpatient psychiatric cases. Early in the development of MMPI patterns, it was discovered that peak scores on scale 4, almost without regard to the absolute elevation of the profile, provided evidence of lack of social conformity or self-control and a persistent tendency to get into scrapes (Schiele, Baker, and Hathaway, 1943). This finding is clearly reflected in the way Meehl (1946) defined the profile characteristics of his conduct-disorder cases. When Hathaway and Monachesi (1953, 1957, 1963) studied the records of delinquent boys, they found a high frequency of peak scores on scale 4. The special effects of combinations with other scales as second high points and of differences in absolute elevation, however, can be seen in their data on two-point high points. Thus, when scale 4 as peak is paired with scales 1, 7, or particularly 2, the delinquency rate is reduced below the level expected for boys in general. When scale 4 is found in combination with scales 3, 8, and particularly 9, the delinquency rate is greatly elevated. In the 49 combination, for example, the eighty-five boys with this pattern (Hathaway and Monachesi, 1953) have a delinquency rate of 38 percent as compared with the 22 percent found for all boys in the study without regard to MMPI scores. In this group the effect of higher elevations of the pattern is also dramatically shown. The forty boys with 49 patterns that were at a primed level had a delinquency rate of 51 percent! Similar trends can be seen in the data from the girls, although the over-all delinquency rates were lower for the female group. The college women in the study carried out by Black described the high 4 girls as sociable, arrogant, frivolous, incoherent, moody, and partial. These terms are quite unflattering on the whole, as are the significant omissions (by implication) that Black found in his analysis: practical, cheerful, selfcontrolled, and conventional were not used to describe high 4 s. This unprepossessing set of terms may stem in part from the fact that the peer judges were living closely with the girls they rated and depended heavily upon their cooperation and willingness to share domestic responsibilities.

In their self-descriptions, the high 4 girls in Black's study were quite insensitive to the social favorability of the items. They rated themselves as apathetic, cynical, dishonest, clever, lively, and worldly. They left out of their self-descriptions to a significant extent the terms adaptable, practical, kind, easily bored, friendly, peaceable, and natural. Mello and Guthrie reported that few of the cases with peaks on scale 4 seen in a university counseling center showed the classic asocial, amoral psychopathic pattern. This finding is understandable in the light of the referral policies of the center, most of the cases being self-referred. The role of scale 4 appeared to be an index of rebelliousness rather than an indication of the acting out of base impulses. These subjects resented authority and were hostile toward their parents, whom they blamed for all their problems. Their immediate concerns centered

about vocational choices. The indecisive states of these college students were complicated by unstable relationships with the opposite sex and, at times, by a rejecting father. They continued to return to the center for their scheduled interviews, but were generally quite resistant to therapy. Since they resorted to intellectualization and stereotyped repetition of their problems, their response to therapy was minimal. Medical patients with peak scores on scale 4 were described by Guthrie as having psychopathic features in their histories, particularly when their second high score fell on scale 2, 3, 6, or 9. That is, men with this profile tended to be alcoholic, to gamble excessively, or to show poor work records. For the women there were comparable indications that they had gone against social mores; they had histories of recurrent marital difficulties, illegitimate pregnancies, and the like. Their symptoms were episodic in nature, mild in degree, and overshadowed by their behavioral difficulties. Since they were unreliable patients, their response to treatment was difficult to assess. Deeper personality conflicts appeared in the groups with scale 7 or 8 in second place in the profile. Gilberstadt and Duker reported a 4 pattern in their code groups also (see Chapter 3 for the defining characteristics of this pattern). As can be seen in the summaries in Volume II on various special problems, scale 4 peaks appear prominently among alcoholic samples (Goss and Morosko, 1969), homeless vagabonds (Brantner, 1958), delinquent subgroups (Stone and Rowley, 1963; Shinohara and Jenkins, 1967; Tsubouchi and Jenkins, 1969; Mack, 1969), disciplinary and sexual offenders within a prison system (Stanton, 1956; Panton, 1958, 1960; Miller and Hannum, 1963; Oliver and Mosher, 1968), drivers with high frequencies of traffic violations and accidents (Buttiglieri, 1969; Waller et al., 1969), and various drug abuse groups (Gilbert and Lombardi, 1967; Ungerleider et al., 1968; McAree, Steffenhagen and Zheutlin, 1969; Smart and Fejer, 1969; and Smart and Jones, 1970). Mack (1969) noted that a 4 spike at the primed level was more frequently associated with recidivism among state training school inmates than those without further legal difficulties, while scale 3 also at a primed level in the profiles of these boys was related to lower likelihood of recidivistic difficulties. (Dahlstrom, Welsh, & Dahlstrom, 1979)

Description:

Problems with law, psychopathic, egocentric, impulsive, superficial rel-s

Possible Diagnoses:

Psychopathy

Modifying Scales

- o When Correction (K) is elevated, they will be more disciplined and less transparent in their manipulations; they may be quite effectively Machiavellian.

- o If Scale 0 is elevated, such individuals can appear cold and self-sufficient with little need for emotional closeness and physical affection. They come across as aloof, angry, and distant, with a remarkable lack of empathy. Some with this pattern can appear paranoid, reflecting a projection of their own cynicism onto others.
- o The elevation of the Harris and Lingoes Pd scales reveals the relative contribution of the various components of Scale 4. When Familial Discord (Pd1) is elevated, look for dysphoria associated with feelings of family abandonment and lack of emotional support.
- o When Authority Problems (Pd2), Antisocial Practices (ASP), or Antisocial Behavior (RCA) are elevated, look for antisocial behavior, acting out, and potential trouble with the law. This is especially true if Social Imperturbability (Pd3) is also elevated.
- o When Social Alienation (Pd4) and Self-Alienation (Pd5) are elevated and the other subscales are not, then look for individuals who feel very disconnected, alone, and alienated from others. This may be the result of a recent reactive disorder subsequent to some kind of transition or loss.
- o When Scale 9 is in the normal range but Psychomotor Acceleration (Ma) is elevated above a T-score of 65 or 70, the individuals may exhibit 4-9 code-type personality characteristics of assertive or even aggressive acting out. This is especially true if Antisocial Practices (ASP) is elevated.
- o When Bizarre Mentation (BIZ), Psychoticism (PSYC), or Aberrant Experiences (RC8), are elevated and Scale 8 is not, then beware of potentially bizarre acting-out behavior.
- o The elevations of the MacAndrew Alcoholism Scale-Revised (MAC-R), Addiction Acknowledgment (AAS), or Addiction Potential (APS) would aggravate acting-out behavior, especially when under the influence of chemical agents. Chemical addiction or abuse is suggested.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Male

Low 0 Father conflict, aggressive or belligerent.

Female

Low 0 Lacks academic drive, socially extroverted.

Low 1/2 Socially extroverted.

Low 5 Lacks skills with the opposite sex, indecisive, rebellious toward home, anxieties.

Low 6 Vague goals.

(Drake & Oetting, 1959)

o **Check:** *ASP, RC4, FRS* (low), *OBS* (low), *ANG1, ASP1, ASP2, LSE1* (low), *LSE2* (low), *SOD1, SOD2* (low), *FAM1, FAM2, AGGR, DISC, Pd1, Pd3, Pd4, Pd5, Ma1, Ma3, Si1* (low), *Si2, A, R, O-H, GF* (low), *MAC-R, AAS, MDS*.

TREATMENT

Working on the transference is important, as they generally distrust authority figures and project their own manipulateness onto the therapist. Asking direct questions about their experience of the therapeutic process would allow them to express criticism of the therapist without being emotionally abandoned by the therapist. This could provide a corrective emotional experience around trusting others with vulnerable feelings. Explore childhood memories of feeling alone and unable to trust the emotional stability of caretakers. Help them see how they have developed a “survivor” profile whereby they see relationships as “dog eat dog” interactions. CBT, teaching them empathy, and rehearsing stress-reducing behaviors that are not impulsive could help them anticipate and manage impulse pressures. Help them realize how in intimate moments they experience emotional numbing.

Treatment: Little or no motivation to change; sees problems as caused by others. Treatment can sometimes be initiated around the issue of patient’s judgment. May benefit from substance abuse treatment.

Therapy and Therapeutic Pitfalls

The essence of Spike Scale 4 is distrust and difficulty with emotional closeness and vulnerability. Although these clients may appear independent, self-sufficient, and charming, they can be hard to engage in therapy, as they tend to project onto the therapist their own role playing and manipulations. They are inclined to distrust therapists and to see therapy as “a game” or role play. Dealing with this transference on an ongoing basis is important to facilitate discussing their fears of trusting. Recalling moments when they felt unfairly punished or emotionally abandoned

with no one to turn to could partially help recognition of their numbed emotional response to these events. Gestalt techniques addressing how clients feel “this moment,” including toward the therapist, could maintain their emotional

arousal and involvement in the therapeutic process. Helping clients understand how they learned from an early age to numb their emotions in response to stress could make it easier for them to relearn emotional responsiveness. In some cases it can be productive to explain how switching off emotional arousal robs them of normal levels of excitement and results in their experiencing life as somewhat boring, emotionally dull, and lacking in richness. Help them “try on for size” different emotional states to see if they can gain a sense of empathy for how most people feel. Emotion-focused therapy can be useful in helping them gain awareness of their feelings (Greenberg, 2002). Explore how, given their circumstances, their numbing of emotional vulnerability was adaptive but now leads to reckless excitement-seeking behavior. Short-term therapy can focus on strategies for improving impulse control and managing stress. Learning how to anticipate stressful situations and developing alternative tension-reducing behaviors can minimize rash, angry, and hedonistic responses to pressure. Developing an inventory of self-destructive events resulting from impulsive behavior and using hindsight to learn new coping strategies could reduce the likelihood of future acting out. These clients respond best to a strong, but supportive, therapist who sets limits. Staying open to discussing the therapeutic relationship makes the therapy sessions more immediate and therefore less boring to them. The dynamics and immediacy of group therapy can also keep them more stimulated and involved.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Treatment and Self-Help Suggestions

1. Work with your therapist to discover moments as a child when you felt unfairly punished or when you consciously turned off your feelings to avoid being hurt. Your therapist will help you understand how you have numbed your emotions and also will help you understand the role that emotions play in daily decisions, relationships, and a successful career.¹
2. Work with your therapist to “try on for size” different emotional states that most people feel. Then learn to identify your feelings. Emotional awareness begins with identifying bodily sensations (e.g., clenched fists, racing heart). The next step is labeling the emotion and then finally linking the feeling to a precipitating event. The better you become at identifying your feelings, the more proficient you will be in taking corrective action, dealing effectively with others and maintaining confidence in your abilities.²

3. Explore how you can avoid being impulsive by visualizing stressful situations and rehearsing alternative coping strategies. Find ways to live an exciting and risk-taking life that is not reckless. Avoid chemical agents because they tend to increase your propensity for impulsiveness. Anticipate situations where you might act recklessly, and find alternative behaviors so that you don't ruin the things that you have worked for. Work with your therapist to identify a specific problem situation, and take an objective look at the consequences. Find alternatives, develop a plan, be specific, and put it in writing. Once you have had a chance to test it out, evaluate the outcome to see if the plan needs revising.
4. Resilience building: Making lasting change is hard work, especially under stressful situations. If you are struggling, you may have lost sight of your goals, values, and your passion for what life holds. Reminding yourself about what motivates and drives you helps committing to change. Either write or record what you envision your life to be like 15 years from now. Where will you live, who will be with you, and what will life "look" like? This exercise can help you reconnect with your passion and your incentives for making positive changes.³
5. Because you live a life of selective reporting or lying, it's hard for you to trust what others say to you, even when it is positive. You assume others manipulate and lie because you do. Work on being meticulously honest, telling people what you want and how you feel so that you can learn what it's like to live an authentic life, without having to lie and selectively report.
6. Learn and rehearse ways to express anger so you don't wait until you are hijacked by intense, enraged emotions that can ruin your relationships and derail your life. Some people hold the belief that you need to "vent" your anger or it will build up inside them like steam. Research has actually shown the opposite: simply venting makes you only angrier. Healthy ways of coping with anger involve looking at your responsibility in the situation and learning how to problem-solve instead of dwelling on punishing the other person.

¹ George Vaillant, as part of his research into adult development, conducted a longitudinal study of 450 boys to examine the relative contributions of resilience and intelligence. IQ had little correlation to adult personal and professional success in life, whereas childhood abilities such as frustration-tolerance, and emotional control had greater predictive validity of adult success (Felsman & Vaillant, 1987).

² A comprehensive guide to helping clients manage their feelings can be found in *Emotion Focused*

Therapy: Coaching Clients to Work Through Their Feelings (Greenberg, 2002). The author makes a convincing case for the importance of emotions in the story of a client with impaired emotional responses due to brain damage; although his IQ was not affected, he decided to drive in a fierce snowstorm because he didn't experience the emotion of fear (p. 4).

³ This exercise is outlined in *Primal Leadership: Learning to Lead With Intelligence* (Goleman, Boyatzis, & McKee, 2002, p. 116). Motivation to change is discussed in terms of activating the left prefrontal cortex, the seat of planning and imagining goals, through excitement and hope. (Levak, Siegel, Nichols, & Stolberg, 2011)

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you are an excitement-seeking, adventurous individual who is sensitive to being controlled. People with your profile often grow up in environments where, from an early age, they felt they had to be “survivors,” relying on themselves emotionally because the authority figures in their lives were not trustworthy. In some cases it was because parents were self-centered and inconsistent. In others, parents abused their authority or they allowed you to get away with acting out. Perhaps that's why you learned from an early age to be somewhat manipulative and tell lies in order to get your needs met. Your profile suggests that you are able to make a good first impression with people, but persevering toward long-term goals and being reliable is more difficult. You have a tendency to be impulsive and to make decisions based on immediate desires rather than postponing gratification for long-term goals. At times, your impulsiveness may get you into trouble and you may use your manipulative skills in order to avoid negative consequences.

Though you may be skilled at getting along with people for periods of time, letting down your emotional guard and trusting those closest to you is more difficult. You might see the world as “dog eat dog place,” where you need control and authority over others in order to feel safe. Work with your therapist to understand how you developed a tendency to be a “survivor,” relying on yourself and your ability to manipulate others in order to get your needs met. Explore any childhood memories where you felt emotionally abandoned or mistreated and responded by numbing yourself. Anticipate situations where you might be tempted to behave impulsively and rehearse strategies to deal with stress so you do not act in self-defeating and reckless ways. People with your profile often use chemical agents as a way of “feeling alive.” Discuss any chemical use with your therapist and find exciting and risk-taking activities that are not dangerous or self-destructive.

Feedback Statements—Elevated Profiles (T-Score > 65)

Strengths

Your profile shows you have a number of positive strengths. You are willing to challenge the established way of doing things, and you're not afraid to look at things from a new and different perspective. You are an independent, excitement-seeking, and somewhat risk-taking individual who learned, from an early age, to be a survivor.

Manipulative or Alienated

You may also have learned that being manipulative is how one gets along in the world. You may see the world as a "dog-eat-dog" place where being "top dog" is the only solution. You may find yourself seeking positions of power and control to avoid others having control over you. It's hard for you to trust other people or to let down your guard and ask others for emotional support. Your fear is that if you reveal your weaknesses to others, they will somehow exploit you by using that against you. Others may see you as more manipulative and devious than you see yourself. As you had to learn from an early age to manipulate your parents to get your needs met, you may have learned to "selectively report", to tell white lies, and even to openly lie as a way of avoiding conflict or negative consequences.

Numbs Feelings or Excitement Seeking

You probably learned to numb your emotions and not let yourself feel: as a result, you may experience the world as somewhat boring and lacking in intensity and excitement. Small, everyday events and even things that give other people a sense of excitement may leave you numb, empty, and unable to enjoy life. You may look for stimulation and excitement by doing dangerous and reckless things.

Bored or Restless in Relationships

Although people may find you attractive and you enjoy socializing, you find it difficult to allow yourself to be committed, let your guard down, and be emotionally close. You may become involved with others, and initially you may care a great deal for them but you seem to get bored and restless quickly. You may find yourself being promiscuous and having difficulty maintaining long-term, one-on-one relationships.

Rule Breaking

Sometimes people with your profile have trouble with the law or with authority figures. Perhaps a parent figure was unreasonable and controlling so you have a deep distrust of authority figures. For you to obey the rules, authority figures have to gain your respect. You tend to look for their flaws and weakness, perhaps justifying why you won't conform and obey basic regulations. Any kind of structured job or situation where others control you can make you tense and angry. You may find yourself resisting authority figures and bending the rules.

Impulsive or Acting Out

When you are stressed, you have a tendency to be impulsive. You seem to be able to manage your emotions for periods of time perhaps because you feel numb a lot of the time, but as stress builds you may impulsively turn to alcohol, drugs, food, gambling, and sexual acting out as a way of feeling better. However, your acting-out behavior may create serious negative consequences. When your impulses get you in trouble, it is easy to feel like the world has mistreated you, and in these situations you feel quite down and defeated. You tend to see your problems as due to difficult situations and difficult people rather than as a consequence of your own behavior. When you use drugs or alcohol, your impulsive behavior may get worse, and you may do things that backfire and cause you severe problems.

Lifestyle and Background Feedback

Perhaps you grew up in an environment where one of your parents was controlling or even arbitrary and unreasonable. From an early age, you learned not to trust that parent, perhaps because the parent could be rejecting and abandon you emotionally if he or she were angry. At other times, one parent may have been indulgent and easily forgiving. You learned not to be vulnerable and to not let your guard down. You've learned to numb your vulnerable feelings, to rely on yourself for emotional support, and to not let yourself care too much about others' feelings in case you get hurt or let down.

Normal-Range Feedback (T-Score 50 to 65)

Your profile suggests that you are an independent and self-sufficient person who likes excitement and challenges. You are probably cautious about opening up too quickly with people and letting go of emotional control. You tend to rely on your own resources in times of stress, and you don't trust others easily. You can work satisfactorily in structured situations, but you work best when you have independence and your relationship with authority is clearly defined. Authority figures that approach you in a domineering manner probably provoke an argumentative or resistant response. Abuse of power tends to anger you, and you don't tolerate it as well as other people might. (Levak, Siegel, Nichols, & Stolberg, 2011)

Relations with Other Scales

High 4, Low 5 Code

In men, a low Scale 5 reflects traditional male interests and activities. Typically they are action-oriented, practical, and lack psychological-mindedness. High 4 low 5 males tend to view relationships with women in terms of power and control. They also exhibit more aggressive and impulsive acting-out behavior and sexual promiscuity. Power, coarseness, and traditional masculine interests are emphasized. In working-class men without a college education, this usually reflects a traditional masculine, macho orientation. In an educated male, it would reflect an individual

with non-aesthetic, traditional masculine values and interests. Regardless of educational levels, their relationship with women often is power-oriented, with attempts to control women, sometimes in a demeaning manner. The low Scale 5 increases the possibility of aggressive and impulsive acting-out behavior.

Women with a high 4, low 5 codetype are passive-dependent and/or co-dependent, and so often become involved in relationships that are self-defeating. The low Scale 5 modifies the acting out suggested by Scale 4. Alienation and anger tend to be expressed indirectly. Intimate relationships are hampered by passivity and difficulties with trust. The interaction of an elevated Scale 4 and low Scale 5 in women suggests dependency as well as anger and distrust. These women often are superficial in their relations and frequently have identified with cultural stereotypes of women who are demure, yielding, and alluring. They are often passive-aggressive, using sexuality to manipulate others. When Scale 3 is also elevated, hostility is denied. Marital and family problems are common, as is sexual dysfunction and lack of sexual enjoyment, though many of these women are sexually provocative. Headaches and backaches are also frequent. Treatment should focus on helping them recognize that their ability to achieve intimacy and closeness is hampered by their fears of emotional vulnerability.

41/14 Codes

See 14/41 Codes.

Guthrie noted briefly that for a small group within the population of medical patients he studied the role of scale 4 was obscured by the contributions of scale 1. That is, the 41 patients were clearly hypochondriacal with severe symptoms, there being little clear evidence of asocial behavior. They presented problems that were very resistant to treatment.

(Dahlstrom, Welsh, & Dahlstrom, 1979)

42/24 Codes

See 24/42 Codes.

The psychopathic features of this code type, like those of the 24 group, are prominent and correspond to long-standing behavioral patterns such as alcoholism; on the other hand, the depressive features appear to be situationally produced and short-lived. While guilt and self-depreciation may be part of the presenting picture of these persons, such manifestations are not usually very convincing or sincere. When both scales in this high-point pair are grossly elevated, the pattern is associated with psychotic or prepsychotic behavior, and suicide is a serious possibility.

Guthrie reported that medical patients with this profile type showed physical symptoms in only half of the cases. They impressed the internist as being severely psychoneurotic with psychopathic features, although some of the women with gross elevations were considered prepsychotic. Alcoholism and peptic ulcers were noteworthy in the small group of 42 men. There was little evidence of any response to treatment on the part of these patients. Sheppard et al. (1969) included a 4-2 code pattern group in their analysis of subgroups of heroin addicts at a New York narcotic addiction center. Patterns of self-description in Plutchik's (1962) emotional model were reported on this group which characterized them as higher than other addicts on the incorporation, reproduction, exploration, and protection dimensions, all relatively positive features.

(Dahlstrom, Welsh, & Dahlstrom, 1979)

4-2 See also the 2-4 combination, p. 103.

1. People with the 4-2 combination may seem to be depressed and feeling guilty, but they are not always very convincing or sincere in these feelings (Dahlstrom et al., 1972).
2. People with the 4-2 pattern say one thing, but their behavior is the opposite. For example, they may be self-condemning but act out continuously (Caldwell, 1972).
3. They tend to put their problems on other people so that other people will feel guilty (Caldwell, 1972).
4. When a person with an elevated 4 scale gives responses that indicate difficulty with parents and family, the usual interpretation is that the client, in fact, is the difficult one, and the family often has put up with considerable disruption from him/her. However, when the 2 scale is also elevated, the family may truly have been difficult in some way such as one parent being alcoholic or emotionally explosive. The client's report may reflect a real situation rather than a psychopathic interpretation of reality.
5. The 2-4/4-2 code type occurred most frequently in four alcoholism treatment centers. It accounted for 12 to 21% of the profiles in any facility (Schroeder & Piercy, 1979).
6. In a recent study of heroin addicts (Craig, 1984a) 14% had the 4-2/2-4 profile. The only code with a higher percentage of cases was the 4-9/9-4 code.
7. Anderson and Bauer (1984) have found that college students with high 4-2 (and also elevated 7 and scales) had
 - a. poor relationships with the opposite sex,
 - b. significantly more depression than other clients,
 - c. low self-esteem,
 - d. many problems with their families,
 - e. rigid rules,

- f. dependency, and
- g. no improvement in therapy.

43/34 Codes

See 34/43 Codes.

Like 34, this pattern reflects problems in impulse control and social conformity. However, the relatively greater rise on scale 4 indicates that the controls are even less adequate than for the 34 group. Therefore, as noted by Welsh and Sullivan (1952b), persons with this configuration (particularly when scale 6 is also elevated), although inhibited and moderate, episodically express their aggressive feelings directly and intensely. They are characterized by chronic hostility and aggressive feelings.

In the medical patients he studied, Guthrie found the physical complaints to be mild, episodic, and with little basis in physical pathology. Their psychopathic tendencies were evident, including alcoholism, marital disharmony, and sexual promiscuity. Many cases showed an alternation in their histories between periods of acting out and hysterically determined illnesses.

Thus, these persons have a strong impulse toward socially disapproved behavior, with rather ineffectual controls, but nevertheless suffer from conflicts and anxieties about their actions. This 43 pattern also was represented in the code groups reported by Gilberstadt and Duker (see Chapter 3 for the defining characteristics of this pattern). J. Sines (1966) noted the high prevalence in 43 code patterns found among male prisoners in the Missouri prison system of a history of violent crimes. Persons and Marks (1971) verified and extended this relationship on male cases with 43 codes found in an Ohio reformatory.
(Dahlstrom, Welsh, & Dahlstrom, 1979)

4-3 See also the 3-4 combination, p. 128; the 4-3-5 combination, p. 149.

1. The elevation of scale 4 indicates the amount of aggressive or hostile feelings present, while the elevation of scale 3 indicates the repressive or suppressive controls available. Consequently, because scale 4 is higher than scale 3 in this combination, the controls seen in scale 3 are not always adequate limits. Therefore, the person tends periodically to break out into violent behavior.
 - a. A life-long pattern may exist of over-control, a sudden explosive episode, and then quiet again for about two years until the next episode. The pattern has been found in male and females (Davis, 1971; Davis & Sines, 1971; Persons & Marks, 1971).

- b. Caldwell (1972) saw the 4-3 person as a socially correct role player who periodically breaks out into antisocial behavior.
2. Gilberstadt and Duker (1965) found the 4-3 pattern in a VA hospital male population. A person with this pattern tended to be sensitive to rejection and had poorly controlled anger with temper outbursts. Suicide attempts and alcoholism occurred when this anger turned inward. The Gilberstadt and Duker book should be consulted for further information concerning this profile.
 3. However, a more recent study (Gynther, Altman, & Warbin, 1973c) has failed to replicate the findings of antisocial and violent behavior for the 4-3 pattern.
 4. Megargee and Bohn (1979) found a group of incarcerated criminals with this 4-3 combination (32% of Group Easy). This pattern might have been produced by a fake good tendency. These criminals were the best adjusted and best controlled of the ten groups of prisoners. They had a relatively easy time of it in the prison and the lowest recidivism rate. The Megargee and Bohn book should be consulted for further information concerning this profile group.

435 Code

(5 scale T = 45 or Below)

This pattern may be found for a woman who is hostile and aggressive. She represses anger, but she is unable to prevent her feelings from being acted out. Consequently, she resorts to overt masochistic behavior, which is intended to provoke rage in others.

She can then pity herself for being mistreated (Carson, 1969).

45/54 Codes

This codetype is usually obtained by men. However, it is also a common codetype among women applicants to reality television shows such as *Survivor*, *The Amazing Race*, and *America's Top Model* (Richard Levak, June 11, 2014, personal communication). The high 5, high 4 woman is assertive, sexually aggressive, manipulative, and comfortable competing with men. Males with this codetype tend to be unconventional, both in appearance and behavior. They challenge rules and rebel against social conventions. They may be intellectual rebels rather than acting-out rebels, and generally are not overtly aggressive and do not act out in obviously delinquent ways. Nevertheless, they have a low tolerance for frustration and can get into trouble because of their impulsive behavior and their tendency to use chemical agents. The elevation on Scale 5 acts as a suppressor of the aggressive, acting-out

behavior that is usually associated with high Scale 4 elevations. However, some teenagers with this codetype can act out overtly in antisocial ways, perhaps by dealing drugs or cheating on tests, and other precursors to white-collar crime. The high 4, high 5 male is gregarious, extraverted, and generally well liked by his peers. In therapy they show good rapport and ego strength, and have a reasonably good prognosis. College-educated men with this profile can exhibit narcissism and nonconformity and become involved in social protests, causes, or movements that have an antiestablishment focus. These men can be idealistic and self-aware, and are able to communicate their ideas clearly and effectively, though their anti-establishment views may provide an intellectually rationalized outlet for their anger. Others may view them as self-centered, easily hurt, demanding, and manipulatively dependent. When Scale 3 is the next highest scale, the person is more overcontrolled, passively aggressive, and less insightful (see 345/435/534 codes). When Scale 9 is coded third, these individuals emphasize action, dominance, and control of situations and people, although, unless frustrated, these individuals generally achieve this through charm.

This high point pair is most common among men, and it suggests a chronic character disorder in clients appearing to experience minimal psychic distress. Any occurring depression or anxiety usually is situational in nature. Individuals with this high point pair have nonconforming and defiant attitudes and values as well as aggressive and antisocial tendencies. They exhibit emotional passivity and poorly recognized desires for dependency. Dependency conflicts may be acted out and create masculine protest types of behaviors as well as a variety of conduct disturbances. The guilt feelings and remorse about such actions may temporarily prevent further expression. However, their strong tendency to narcissistically indulge themselves and their lack of frustration tolerance probably will determine their behaviors. They tend to have sexual identity concerns and may, in fact, be preoccupied regarding homoerotic impulses. There is a fear of female domination. Females obtaining this high point pair usually are rebelling against cultural stereotypes of femininity and although they have strong needs for dependency, they fear domination by significant others.

o Like Spike 4 but better socialized. Openly nonconformist; antiestablishment in dress and outlook. Angry disidentification with social convention; quick to view authorities as corrupt, and may defy and rebel against institutional authority through social protest, demonstration, and so forth. Overreactive. Ego-dystonic passivity and dependency with self-centeredness, resentment of demands/responsibility, impulsiveness. Often verbally fluent and articulate if not histrionic. May use idealistic posturing for rebellious, selfish, or exploitive ends. More exploitive than predatory. Look for a history of absent fathers, passive aggression, passive antisocial behavior (e.g., substance abuse), and sexual disturbance (including sex offenses; paraphilia) among men, and tendencies toward abuse/violence among women. Check third highest scale.

Symptoms and Behaviors

High scores on Scales 4 and 5 reflect persons who have difficulty incorporating societal values. For the most part, they can control antisocial feelings, but they may have brief episodes of acting out associated with low frustration tolerance and underlying anger and resentment. Their usual coping style is through passive-aggressive means. Overt homosexuals who make obvious displays of their orientation may have this code, especially if Scales 4 and 5 are the only peaks in an otherwise normal profile. The 45/54 code should in no way be considered diagnostic of homosexuality but simply, at times, is consistent with a subgroup of persons who have this orientation. To obtain further information associated with this or any profile in which Scale 5 is a high point, it is extremely helpful to interpret the third-highest scale and give it the degree of importance usually associated with the second highest point. Thus, a profile in which 4, 5, and 6 are all high might be interpreted as though it were a 46/64 code type.

Some important differences exist between males and females who have this code. First, it occurs much more frequently among men. Males with this code type will be openly nonconformist, but if they are from higher educational levels, they will be more likely to direct their dissatisfaction into social causes and express organized dissent toward the mainstream culture. If 9 is correspondingly high, they will be dissatisfied with their culture, sensitive, and aware, but will also have the energy to attempt to create change. They are often psychologically sophisticated, and can communicate clearly and openly. In contrast, elevated Scales 4 and 9, accompanied by a low Scale 5, suggest a high probability of sexual acting out and the probable development of a “Don Juan” personality. These men are self-centered and have difficulty delaying their gratification. Behind their overt display of affection is an underlying current of hostility.

Females with the 45/54 code will be openly rebelling against the traditional feminine role. Often, this rebellion is motivated by an intense fear related to developing dependent relationships. A further alternative interpretation is that these women are merely involved in a subculture or occupation that emphasizes traditionally male-oriented activities.

Personality and Interpersonal Characteristics

Persons with this profile are immature, self-centered, and inner-directed, and are not only nonconformist but also likely to openly express this nonconformity in a challenging, confrontive manner. They may also have significant problems with sexual identity and experience sexual dysfunction. A further area of conflict revolves around ambivalence

relating to strong but unrecognized dependency needs.

4-5 See also the 5-4 combination, p. 171.

1. Men with this pattern may be nonconforming but are not likely to act out in obviously delinquent ways. However, their low tolerance for frustration can lead to brief periods of problem behavior (Graham, 1977).

2. An elevation on scale 5 may act as a suppressor of the acting out behavior that usually would be seen from the high scale 4.

3. Adolescents in treatment with this 4-5/54 pattern (Marks et al., 1974) were seen by their therapists as in better shape than the typical adolescent patient. They had greater ego-resiliency, were adaptive and organized. They also tended to be heavy drug users. The Marks, Seeman, and Haller book should be consulted for further information concerning this profile type.

4. Outpatient psychiatric males with 4-5 frequently had interpersonal problems, especially breaking up with a girlfriend (King & Kelley, 1977),

5. Male college students with this combination tend to have home conflicts, insomnia, restlessness, and worry (Drake & Oetting, 1959).

6. Professed male homosexuals tend to have a high 4-5, whereas ideational homosexuals tend to have a high 3.5 combination (Dahlstrom et al., 1972).

Description:

Antiestablishment, antiauthoritarian, defensive, passively rebellious, ambivalent over dependency/control/sexual identity

Possible Diagnoses:

Narcissistic, Passive-aggressive, Exhibitionism, Opiate abuse, Aggression

Male

Low 0 Father conflict, aggressive or belligerent. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, lack of skills with the opposite sex, being nonresponsive or a nonrelator, tension.

Low 1 Home conflict, restless.

Nothing Low Home conflict, insomnia.

Female

Low 0 Socially extroverted, lacks academic drive.

Low 1/2 Socially extroverted.

Low 6 Vague goals.

Nothing Low Distractible in study.

(Drake & Oetting, 1959)

TREATMENT

See also treatment section of Spike 4. Typical problem areas for the 45 male are intimacy, trustworthiness, and impulse control, particularly sexual acting out. The 45 codetype has been associated with male sexual offenders, reflecting immaturity and poor judgment. In men, this codetype predicts internal conflict between strong needs for ego gratification and emotional succorance, and the need for autonomy and fears of being controlled. Therapy should focus on helping them learn to express their feelings directly rather than selectively report or manipulate others. Impulse control to manage their sexual acting out could also be an appropriate focus. Look for a strong relationship with a narcissistic mother figure in which the patient felt controlled but also indulged. In women, look for a strong male figure who was controlling and unreasonable. The high 4 individual generally needs to learn how to be emotionally vulnerable, so exploring emotional trust issues would be an important focus in therapy.

Treatment Implications

Although persons with this profile are guarded and defensive about revealing themselves, they are also capable of thinking clearly and have good insight into their behavior. They rarely report for treatment because they typically are satisfied with themselves and their behavior. They usually do not report being emotionally distressed. When they do seek treatment, issues are likely to center on dominance and dependence. Significant change is unlikely because of the chronic, ingrained nature of their personality.

THERAPEUTIC FEEDBACK LANGUAGE

45 male: Your profile suggests that you have a balance of masculine and feminine interests and values. You enjoy artistic, creative, and intellectual activities. Talking about ideas, philosophy, and how people feel is interesting to you. You tend to reject stereotypic masculine interests and values, and you enjoy the company of sensitive people. You also value your independence and resist being controlled. You tend to be a nonconformist, letting others know that you do not follow the rules like they do. You may channel some of your nonconformity and distrust of authority into an alternative lifestyle. At the same time, you have difficulties with trust and emotional intimacy, and you may occasionally act impulsively and in ways that others might see as somewhat selfish or self-absorbed. Work with your therapist to understand what situations may tempt you to be impulsive and non-empathic with others. Learn to tell the truth, even when the situation is difficult, and explore whether you resist authority instinctively, rather than thoughtfully. Explore with your therapist how you can learn to let down your guard emotionally and be more trusting of those close to you.

For 45 women: Your profile suggests that you have a balance of masculine and feminine interests and values. You might have grown up as a tomboy, comfortable with boys and doing things that boys traditionally do. You are practical and action-oriented, and you enjoy the company of men. You are independent and dislike being controlled in any way. You are competitive and a nonconformist. You can also be highly spontaneous, to the point of being impulsive and, at times, reckless. When you get in trouble, it is easy for you to bend the rules, manipulate others, and tell white lies in order to get your needs met. You may have grown up close to a male figure that was controlling and, at times, abused his authority. Work with your therapist to understand how your impulses can get you into trouble. Learn how to avoid bending the rules so that you do not get into trouble. Explore how your need for independence and your dislike of being emotionally vulnerable may hamper you in your close relationships.

456 Code

o Like 4-5/5-4, but narcissistic, hypersensitive, and resentful. Fears domination and may become enraged when frustrated by others. See 4-5/5-4, 4-6/6-4, 5-6/6-5.

Male

Low 0 Father conflict, aggressive or belligerent, worries a great deal.

- Note: Scale coded low was infrequently associated with worrying a great deal. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, lack of skills with the opposite sex, being nonresponsive or a nonrelator, tension.

Low 1 Home conflict, worries a great deal, restless.

Low 2/3/7/8/9 Worries a great deal.

Nothing Low Home conflict, worries a great deal, insomnia.

Female

Low 0 Socially extroverted, lacks academic drive, resistant in the interview.

Low 1/2 Socially extroverted.

Nothing Low Restless, 8+ conferences, distractible in study.

- Note: Scale 5 coded high was infrequently associated with 8+ conferences.

457 Code

o Sexually maladjusted and insecure. Self-centered and exploitive; behavior may antagonize others. May be compulsively promiscuous. See 4-5/5-4, 4-7/7-4, 5-7/7-5.

Male

Low 0 Home conflict, father conflict, one interview only, wants reassurance only, aggressive or belligerent, lacks knowledge or information.

Low 1 Home conflict, wants reassurance only, nonresponsive or nonverbal, restless.

Low 2/3/6/8/9 Home conflict, wants reassurance only.

Nothing Low Lacks skills with the opposite sex, home conflict, mother conflict, sibling conflict, wants reassurance only, nonresponsive or nonverbal, tense, indecisive, unhappy, worries a great deal, insomnia, confused, poor rapport.

- Note: Scale 5 coded high was infrequently associated with tension; Scale 4 coded high was infrequently associated with lack of skills with the opposite sex.

Female

Low 0 Insomnia, rebellious toward home, socially extroverted, lacks academic drive.

Low 1/2 Insomnia, rebellious toward home, socially extroverted.

Low 3 Insomnia, rebellious toward home, cried in the interview.

Low 6 Insomnia, rebellious toward home, vague goals.

Low 8/9 Insomnia, rebellious toward home.

Nothing Low Insomnia, headaches, rebellious toward home, sibling conflict, distractible in study, tense on examinations.

(Drake & Oetting, 1959)

4579 Code

These elevations may indicate home conflict in male college counselees (Drake & Oetting, 1959).

458 Code

o Sexual maladjustment and sexual identity concerns may be relatively severe. See *4-5/5-4, 4-8/8-4, 5-8/8-5*.

Male

Low 0 Home conflict, father conflict, aggressive or belligerent, lacks knowledge or information. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, lack of skills with the opposite sex, being nonresponsive or nonverbal, tension.

Low 1 Home conflict, restless.

Low 2/3/6/7 Home conflict.

Low 9 Home conflict, introverted or self-conscious or socially insecure.

Nothing Low Home conflict, indecisive, unhappy, worries a great deal, insomnia, confused.

Female

Low 0 Depressed, insomnia, overprotective mother, socially extroverted, lacks academic drive, verbal.

- Note: Scale 5 coded high and Scale 0 coded low were infrequently associated with depression.

Low 1 Depressed, insomnia, overprotective mother, socially extroverted.

- Note: Scale 5 coded high was infrequently associated with depression.

Low 2 Depressed (48), insomnia, overprotective mother, socially extroverted.

- Note: Scale 5 coded high was infrequently associated with depression.

Low 3/6/7/9 Depressed, insomnia, overprotective mother.

- Note: Scale 5 coded high was infrequently associated with depression.

Nothing Low Depressed, insomnia, headaches, overprotective mother, mother conflict, father conflict, sibling conflict, distractible in study, lacks skills with the opposite sex, 8+ conferences.

- Note: Scale 5 coded high was infrequently associated with depression and father conflict.

459 Code

o Severe narcissism, exploitiveness, irresponsibility, expediency, hedonism. Psychopathic personality trends but often without extensive legal histories. May be charismatic. See 4-5/5-4, 4-9/9-4, 5-9/9-5.

1. For men with this pattern the high 5 score may be an indication that the 4-9 behavior is suppressed. Therefore, the person may not be acting out directly.

When the 4.5-9 pattern is present in a male college student, the under-achievement which is typically seen with the 4-9 pattern, is not manifested. The 5 scale acts as a suppressor (Drake, 1962).

Male

Low 0 Father conflict, mother conflict, poor rapport, aggressive or belligerent.

- Note: Scale coded low was infrequently associated with poor rapport. This pattern was infrequently associated with introversion or selfconsciousness or social insecurity, shyness in the interview, lack of skills with the opposite sex, being nonresponsive or nonverbal, being nonverbal or a nonrelator, indecisiveness, tension.

Low 1 Home conflict, mother conflict, restless, poor rapport.

Low 2/3 Mother conflict, poor rapport.

Low 6 Mother conflict, poor rapport, rationalizes a great deal.

Low 7/8 Mother conflict, poor rapport.

Nothing Low Mother conflict, home conflict, poor rapport, insomnia

Female

Low 0 Vague goals, marriage oriented, lacks academic drive, verbal, home conflict, socially extroverted.

- Note: Scale coded low was infrequently associated with home conflict.

Low 1 Vague goals, verbal, home conflict, socially extroverted.

Low 2 Vague goals, verbal, home conflict, socially extroverted.

- Note: Scale 2 coded low was infrequently associated with home conflict.

Low 3/6/7/8 Vague goals, verbal, home conflict, socially extroverted.

Nothing Low Vague goals, distractible in study, verbal, home conflict, socially extroverted.

(Drake & Oetting, 1959)

46/64 Codes

Code-Type 4-6/6-4

Descriptors

Complaints

Resentment, hurt feelings, sometimes complaints of depression, sensitive to criticism, irritable, sometimes somatic (headaches, cardiac complaints), high needs for attention and affection, slow to forgive, can experience paranoid ideation, acts out when stressed

Thoughts

Resentful, hyper-rational, defensive, projects and externalizes blame, suspicious of others' motives, can be paranoid, resists authority

Emotions

Tense, irritable, dysphoric, feels unfairly treated, feels unloved and unsupported, self-centered, self-indulgent, angry

Traits and Behaviors

Demanding, argumentative, sensitive, blaming, easily hurt, slow to forgive, possibly suicidal in an angry way when severely stressed, sometimes alcohol or chemical addictive

(Levak, Siegel, Nichols, & Stolberg, 2011)

Therapist's Notes

In the normal range the 4-6 profiles reflect individuals who are sensitive to others making demands on them. They are thin-skinned and quick to feel controlled or criticized. They value independence and speak their mind, especially if they feel unfairly treated. At higher elevations, the 4-6 individuals go through life angry, resentful, and ready to argue, as if anticipating others will make unfair or unreasonable demands on them. They feel on edge and go to great lengths to guard their boundaries from being violated in the form of demands or censure of their behavior; they are ready to protect themselves verbally or sometimes physically. Our hypothesis is that they experienced criticism, will-breaking control, and severe punishment as children. Their adaptive response was to generalize self-protection and to become vigilant in warding off any affronts to their sense of pride, self-sufficiency, and autonomy. When they

make demands, they tend to do so angrily, with a self-justification that inspires argumentativeness and resentment in others. When 4-6 code types feel unfairly treated, they feel deeply wounded, slighted, and vengeful. Episodic failures of empathy toward them by others are experienced as assaults to their dignity and a violation of their rights, and they feel they need to respond with vengeance and even vindictiveness. This argumentative, angry stance toward the world extends to authority figures, especially those they see as controlling or arbitrary. They feel justified in resisting and undermining authority, generalizing their resentment toward arbitrary, shaming parental figures. Therapists describe them as irritable, aggressive, demanding, egocentric, and self-indulgent. They are often seen as evasive and argumentative by their therapist, reflecting their fear that probing into their inner world is an attempt to expose their weakness and vulnerability and to dominate and humiliate them. They tend to defensively disparage others, sometimes in subtle and, at other times, more overt ways.

These clients deny responsibility for their difficulties, and they project and externalize blame. Revealing internal vulnerabilities would leave them exposed to criticism and judgment, so they tend to be defensive and argumentative. They see much communication as if it were an argument, and they spend a great deal of time attempting to rationalize their behaviors as “above criticism.” Others may see them as somewhat immature, insecure, and manipulative. Their acting out reveals poor judgment and impulsivity. When stressed, their suspicion may shade toward paranoia, projecting their own self-centeredness and tendency to manipulate onto others. When crossed or hurt, individuals with this code type tend to be unforgiving and accumulate resentments. Perhaps because they are so sensitive and have interpreted criticism and rejection as mean-spirited and cruel, they protect themselves against the vulnerability associated with the forgiveness of others. Yet they demand affection and loyalty from others. They expect people to let them down and hurt them, so they demand symbolic displays of loyalty. If confronted for a transgression, they become angry, pointing out the other person’s faults and obfuscating their responsibility by attacking their accuser. It is difficult for them to ask for what they want unless they feel completely justified in doing so, and then they do so with resentment. Even if Scale 2 is not elevated, symptoms of depression and anxiety are often reported. The depression tends to be of an angry, alienated, defeated kind rather than a sense of real sadness. The 4-6 clients experience anxiety occasionally, usually reflecting repressed anger and resentment rather than diffuse, neurotic anxiety.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Lifestyle and Family Background

This profile has been called the “Scarlett O’Hara” in females or the “chip on the shoulder” profile. Typically, these individuals grew up in families where a parent was perceived as controlling, critical, will breaking, severely punishing, and authoritarian. As children, many of these clients exhibited behavior problems, and some were

delinquent and some hyper-sexual. Many report mothers who were strict, rejecting, or even indifferent. Our hypothesis is that, as children, they adapted to a rejecting, at times cruel, yet controlling environment by becoming hypersensitive to any invasion of boundaries. Hypervigilance, resentment, anger, argumentativeness, and emotional numbness served as adaptive responses to will-breaking, punishing, and controlling parents. These clients go through life vigilant, as if all communication were a zero-sum game. They often report interpersonal conflicts and marriage difficulties. They are extremely sensitive to unfairness and to being shamed. Prone to intense, abrupt, angry temper outbursts, some can become violent, especially if they feel unfairly treated or criticized. Their rage can occasionally erupt as impulsive suicide that is punishing of others rather than depression related.

(Levak, Siegel, Nichols, & Stolberg, 2011)

The 46 codetype reflects a resentful, angry, distrustful individual who approaches life with vigilance for how others may use them or take advantage of them. Their stance in life is one of defensiveness and, though demanding of others, they are hypersensitive to demands being placed on them. They readily feel rejected or criticized, and they are quick to jump to the conclusion that others are treating them unfairly or attempting to take advantage of them. They feel chronically hurt and ruminate how others have mistreated them and how they need to protect themselves or seek revenge. They have limited awareness of how they contribute to their difficulties. They experience interpersonal problems and family conflicts, and tend to project blame onto others. This is a divorce-prone profile. The 46 individual craves affection and validation, but demands it in ways that alienate others, who then resist giving it, thus confirming the 46 view of relationships as exploitive. They are subtly argumentative and defensive, which elicits anger from others.

Older adolescents with this codetype experience problems with their caregivers as well as with authority figures, in general, who see them as hostile, deceitful, argumentative, and blaming. 46 teenagers are highly self-indulgent and under-control their impulses. They rarely take responsibility for their behavior and are negative and argumentative. In some cases, the extreme sensitivity of the 46 can shade towards paranoia, with jealousies, suspicions, and distrust of others. Anger is a predominant feature of this codetype. However, if Scale 6 is more elevated than Scale 4, the individual can manifest paranoid ideation and in some cases there can be psychotic symptoms. As anger builds, the 46 individual can justify aggressive behavior, especially if they feel wronged or slighted. Threats of violence should be taken seriously. If Scale 5 is low in a 46 woman, the anger is expressed more as passive aggression and an almost masochistic interpersonal style in which they allow others to take advantage of them. The 46 low 5 codetype was well portrayed by the character of Scarlett O'Hara in *Gone With the Wind*.

- o Immature, narcissistic, self---indulgent; passive dependent; makes excessive demands on others for attention and sympathy; resentful of demands made on them; females overly identified with traditional female role and very dependent on males; doesn't get along well with others, especially members of opposite sex; suspicious of motivation of others; avoids deep emotional involvement; repressed hostility and anger; irritable, sullen, argumentative, generally obnoxious; resentful of authority
- o Denies serious psychological problems; rationalizes, transfers blame; can't accept responsibility for own behavior; unrealistic and grandiose in self--- appraisals; unreceptive to psychotherapy; usually diagnosed as passive--- aggressive personality or schizophrenia, paranoid type

Individuals with this high point pair are likely to accentuate their complaints by a tendency to be selfdramatic and hysteroid. They can be expected to be chronically hostile and resentful and to use projection and acting out as preferred defense mechanisms. Impulse control is likely to be deficient and ineffective, and difficulty will be encountered in any enterprise requiring sustained effort. Individuals with this high point pair tend to be narcissistic, dependent, and quite demanding of attention and sympathy, yet they will not reciprocate and resent demands placed on them. They are extremely sensitive to criticism, mistrust the motives of others, tend to brood and harbor grudges, and feel they are not receiving the appropriate treatment they deserve. A history of social maladjustment is likely. Individuals with this high point pair are often seen by others as irritable, sullen, argumentative, and obnoxious. Serious marital and sexual maladjustment is likely as well as excessive alcohol consumption and/or drug abuse. While the most likely diagnosis is some type of character disorder, the possibility of a borderline or psychotic disorder should be considered, especially if Scale 8 also is elevated. Individuals with this high point pair have difficulty in psychotherapy because denial is prominent and their basic mistrust of the motives of others precludes their acceptance of constructive criticism and attempts to help them. Furthermore, they will be reluctant to discuss emotionally laden topics for fear that dire consequences will follow if they reveal themselves in any way.

Symptoms and Behaviors

Persons with the 46/64 code type are hostile, brooding, distrustful, irritable, immature, self-centered, and usually unable to form close relationships. They have significant levels of social maladjustment often related to continually blaming others for their personal faults. This style of blaming prevents them from developing insight into their own feelings and behavior, because they are constantly focusing on the behavior of others rather than their own. They lack self-criticism, and are highly defensive and argumentative, especially if *L* and *K* are also high. Although they lack self-criticism, they are highly sensitive to real or imagined criticism from others, often inferring hostility or rejection when this was not actually intended. To avoid rejection and maintain a certain level of security, they

become extremely adept at manipulating others. Often, they will have a history of drug addiction or alcohol abuse (check the MAC-R, AAS/Addiction Acknowledgment, and APS/Addiction Potential scales).

Frequent corresponding high points are on Scales 2, 3, and/or 8. Males with high 8s are often psychotic, especially paranoid schizophrenic or prepsychotic, but with 2 and/or 3 also elevated, the chances of a borderline condition are significantly increased. These men are likely to be angry and to have significant conflicts relating to their own denied, but strong, needs for dependency. They are likely to rebel against authority figures and may use suicidal threats to manipulate others. Females with a 46/64 code type may be psychotic or prepsychotic, but they are more often passive-aggressive personalities. If Scale 3 is also elevated, they will have intense needs for affection and will be egocentric and demanding. However, they will be resentful of the demands placed on them by others.

Personality and Interpersonal Characteristics

A core issue is often passive dependency. These individuals frequently have adjustment difficulties associated with their hostility, anger, mistrust, and a tendency to blame others. They tend to avoid deep involvement. People perceive them as sullen, argumentative, obnoxious, and resentful of authority (check the ANG/Anger scale).

o Alienated. Chronic resentment of family and authority. Tense, sullen, irritable, and hostile. Depression, when present, tends to be externalized. Chronic struggles over demands and expectations; quick tempered; demands much of others but resents reciprocal demands on self. Quick to see self as criticized, provoked, exploited, mistreated, or victimized by others (projections), but reluctant to admit to own provocativeness, exploitation, manipulateness, and mistreatment of others. Hyper-rational, stubborn, argumentative, unforgiving, resentful, oversensitive, and hyper-vigilant. Fearful of vulnerability. Men tend to be sullen and vengeful, women tend to be provocative and passive-aggressive. Craves affection but alienates those who would provide it. Shortsighted and self-defeating. Look for history of delinquency and scrapes with authority figures, job losses, and marital conflict or recent loss of significant relationship; rule out psychotic (paranoid) features.

Diagnosis

Psychosis 55%	Schizophrenic/paranoid
Personality disorder 45%+	Mixed
Psychoneurosis 0%	
Brain syndrome 0%	

Personality Description

The characteristics of patients yielding profiles with primary elevations on scales 4 and 6 may be explained through understanding of the constructs underlying these scales; they involve rebelliousness and hostility. Hence, it is not surprising to find that these patients are described as irritable, aggressive, egocentric, and self-indulgent. They have been perceived, virtually unanimously by our clinicians, as evasive and consistently resentful and argumentative. These patients also exhibit their rebelliousness in a persistent disposition to derogate authority figures. These patients are not likely to admit readily their own responsibility for their difficulties; they are seen as defensive and tend to deny psychological conflicts and psychological problems. They rationalize these difficulties in an attempt to make them appear reasonable and justifiable. Alternatively, or concurrently, they readily project the blame for their troubles on others. They resent and are especially sensitive to anything that may be construed to be a demand made on them. At the same time, they are likely to demand sympathy from others. Patients who present this profile are, in general, immature, insecure, indecisive, and passively manipulative. They exhibit poor judgment, are suspicious, and have exaggerated needs for affection and attention. These needs and the egocentric self-indulgent behavior already indicated appear consistent with the narcissism ascribed to these patients by the clinicians who had the opportunity to observe them.

As children, these patients were typically behavior problems. They were often delinquent, sexually and criminally. A number of fathers of patients generating this profile were alcoholic (20%) or mentally ill (15%); they were characterized as permissive and either rejecting or indifferent in their attitude toward the children. The mothers were very similar; 63% were reported to be strict, rejecting, or indifferent. Marriage and sex seem to be areas particularly affected by these patients' disorders. Twenty-five per cent are either divorced or separated. Thirty per cent have had abortions and 15% have given birth to illegitimate children. Another 17% are alcoholic and 28% report drug abuse. Nearly 40% have attempted suicide. Somatic symptoms most often reported include headaches, blackout spells, amnesia, delusions, and cardiac complaints. These patients tend not to respond to treatment; the prognosis is considered poor in 64% of the cases.

Persons with the 46/64 code type are immature, narcissistic, and self-indulgent. They are passive-dependent individuals who make excessive demands on others for attention and sympathy, but they are resentful of even the most mild demands made on them by others. Women with the 46/64 code type seem overly identified with the traditional female role and are very dependent on men. Both 46/64 men and women do not get along well with others in social situations, and they are especially uncomfortable around members of the opposite sex. They are suspicious of the motivations of others and avoid deep emotional involvement. They generally have poor work histories, and marital problems are quite common. Repressed hostility and anger are characteristic of 46/64 persons. They appear to be irritable, sullen, argumentative, and generally obnoxious. They seem to be especially resentful of

authority and may derogate authority figures. Individuals with the 46/64 code type tend to deny serious psychological problems. They rationalize and transfer blame to others, accepting little or no responsibility for their own behavior. They are somewhat unrealistic and grandiose in their self-appraisals. Because they deny serious emotional problems, they generally are not receptive to traditional counseling or psychotherapy. Among psychiatric patients, diagnoses associated with the 46/64 code type are about equally divided between passive-aggressive personality disorder and schizophrenia, paranoid type. In general, as the elevation of scales 4 and 6 increases and as scale 6 becomes higher than scale 4, a prepsychotic or psychotic disorder becomes more likely. 46/64 individuals present vague emotional and physical complaints. They report feeling nervous and depressed, and they are indecisive and insecure. Physical symptoms may include asthma, hay fever, hypertension, headaches, blackout spells, and cardiac complaints.

A small group of medical patients showed this pattern in Guthrie's study. Their physical complaints were varied, both among the patients as a group and for any given patient from one visit to another. Their physical and emotional difficulties were only vaguely described but some cases showed marked anxiety. When the profile was grossly elevated with a 46 pattern, the cases appeared clearly prepsychotic. There was a high incidence of asthma, hay fever, and hypertension, such symptoms in these cases being apparently related to instances of repressed hostility. The social maladjustments of the patients in Guthrie's study are noteworthy. In almost every case there was a report of seriously disrupted relations with the opposite sex, half of the women being divorced or in the process of getting a divorce. When the score on scale 4 was in the primed range, there was also evidence of poor work histories. Both of the men included in this group were alcoholics. In psychiatric cases, the 46 pattern is related to irritability and suspiciousness combined with depression, nervousness, and introversion. Alcoholism may be associated with this pattern as well as defects of judgment. Some form of conduct disorder characterizes the majority of patients, although schizophrenia of the paranoid form and paranoid states may also appear. Neurotic conditions associated with this pattern seem to have neither somatization features nor anxieties or obsessions stemming from deep inner conflicts. Rather neuroticism seems to be related to situational conditions or to circumstances arising out of judgmental defects or other psychopathic difficulties. The 46 pattern is represented in two of the subgroups reported by Marks and Seeman, a 46 pattern and a 462 pattern (see Chapter 3 for the definitions of these patterns). Sheppard, Fiorentino, and Merlis (1968) also reported emotional profiles for various subgroups of heroin addicts, including the 468 pattern which was characterized as higher on the Plutchik (1962) dimensions of protection, exploration, deprivation, and rejection.

(Dahlstrom, Welsh, & Dahlstrom, 1979)

Rules

4 and 6 above 70 Ts

4 minus 2 more than 15 T-scores

4 and/or 6 minus 5 more than 25 T-scores

4 and 6 greater than 8

6 minus 2 more than 10 T-scores

8 greater than 7 and 9

9 and below 70 Ts

L, F, and K below 70 Ts

Most Descriptive

28. Is evasive (9.0) + + +

54. Is defensive about admitting psychological conflicts (8.8) + + +

47. Handles anxieties and conflicts by refusing to recognize their presence (8.4) + + +

98. Is egocentric; self-centered; selfish (8.2) + +

70. Utilizes rationalization as a defense mechanism (8.0) +

85. Has inner conflicts about sexuality (8.0) +

12. Tends not to become involved in things; is passively resistant (7.8) +

78. Is irritable (7.8) +

79. Is resentful (7.8) +

62. Exhibits evidence of narcissism (latent or manifest) (7.6) +

65. Has an exaggerated need for affection (7.6) +

97. Is sensitive to anything that can be construed as a demand (7.6) +

2. Demands sympathy from others (7.4) +

22. Resents authority figures and typically has impulses to resist or derogate them (7.4) +

17. Utilizes projection as a defense mechanism (7.2)

83. Is argumentative (7.2) +

5. Possesses a basic insecurity and need for attention (7.0)

16. Is overanxious about minor matters and reacts to them as if they were emergencies (7.0) +

80. Emphasizes oral pleasures; is self-indulgent (7.0) +

Least Descriptive

7. Psychic conflicts are represented in somatic symptoms (1.2)

- 9. Presents self as being physically, organically sick (1.2) —
- 21. Has multiple neurotic manifestations (1.4)
- 27. Has shown ability to talk about conflicts in most areas (1.4)
- 41. Has good verbal-cognitive insight into own personality structure and dynamics (1.6) —
- 51. Exhibits good heterosexual adjustment (1.6) —
- 67. Is able to sense other person's feelings; is an intuitive, empathic person (1.8)
- 53. Is open and frank in discussing problems (2.0)
- 108. Has the capacity for forming close interpersonal relationships (2.0)
- 95. Accepts others as they are; is not judgmental (2.2) —
- 30. Has "diagnostic" insight; awareness of the descriptive features of own behavior (2.4) —
- 25. Presents a favorable prognosis (2.6) 11. Is cheerful (2.8) +
- 20. Complains of difficulty in going to sleep (2.8)
- 42. Is "normal," healthy, symptom free (2.8) + +
- 45. Thinks and associates in unusual ways; has unconventional thought processes (2.8) —
- 61. Tends to be flippant both in word and gesture (2.8)

4-6 See also the 4-6-5 combination, p. 152.

1. These people may be hostile, resentful, and suspicious (Hovey & Lewis, 1967).
2. People with this pattern tend to transfer blame for their problems onto others (Carson, 1969). They may be litigious and threaten to initiate law suits.
3. These two scale potentiate each other. These people typically have poor impulse control, explosiveness, and a propensity towards violence (Trimboli & Kilgore, 1983).
4. Seriously disruptive relationships with the opposite sex may exist such as divorce (Dahlstrom et al., 1972; Guthrie, 1949),
5. These people tend to have poor work records (Dahlstrom et al., 1972; Guthrie, 1949).
6. Alcoholism or poor judgment may be associated with this pattern.

7. People with this pattern tend to convert everything into anger (Caldwell, 1974).
8. They may demand a great deal of attention for themselves but resent giving any to other people (Graham, 1977).
9. They tend to be poor risks for counseling (Carson, 1969).
10. In one study of women with this profile plus low 5 scale (Walters & Solomon, 1982) the women were indecisive and demanding of love and attention.
11. Marks et al. (1974) found the 4-6/6-4 pattern in a university hospital and outpatient clinic. It tended to be found for females who were described as self-centered, hostile, tense, defensive, and irritable. They usually refused to admit their difficulties, and therefore did not deal with them. They &fluently used rationalization as a primary defense mechanism. The Marks, Seeman, and Haller book should be consulted for further information concerning this pattern.
12. VA hospital males with this profile tended to be socially maladjusted with women. They were confused, resentful, and evasive (Hovey & Lewis, 1967).
13. Adolescents in treatment with this 4-6/6-4 pattern (Marks et al., 1974) were referred because they were defiant, disobedient, tense, restless, and negative. Their relationships with their parent:- were poor. They demanded attention and under-controlled their impulses. About one-half of the group were involved with drugs. The Marks, Seeman, and Haller book should be consulted for further information concerning this profile.
14. For college students with this profile, men tended to be aggressive and belligerent with conflicts with their fathers. Women were rebellious towards their homes, restless, and lacking skills with the opposite sex (Drake & Oetting, 1959).

Description:

Narcissistic, immature, suspicious, angry, transfer-of-blame, seek attention, reject responsibility, intermittent aggression

Possible Diagnoses:

Substance abuse, Oppositional p.d., Paranoid schizophrenia, Somatization, Passive-aggressive, Depression, Paranoia

Modifying Scales

- o When Scale 3 is elevated, social poise, even seductiveness, and attempts to connect, please, and play the right role are evident. The 4-6-3 individuals are skillful social role players, manipulating others through charm, but when crossed can quickly become angry, resentful, and vindictive. Scale 3 masks the angry, argumentativeness of 4-6 individuals, so that they are outwardly conforming, albeit with occasional angry acting out.
- o When Scale 9 is elevated, look for a charming, hyperactive individual who can quickly become hostile, demanding, vindictive, and violent if crossed or rejected.
- o When Family Discord (Pd1) is the primary elevation among the Scale 4 subscales, look for a localized conflict with resentments and anger toward a controlling, demanding, and authoritative parent.
- o When Authority Conflict (Pd2) is elevated there may be a history of delinquency, antisocial acting out, and resistance to authority figures.
- o When Social Alienation (Pd4) and Self Alienation (Pd5) are elevated, these individuals can be withdrawn, keenly sensitive, suspicious, and protective of their privacy.
- o When Persecutory Ideas (Pa1) is elevated, look for a more paranoid disorder.
- o When Naïveté (Pa3) is elevated higher than the other Scale 6 subscales, this indicates a self-righteous, morally rigid, and inflexible individual.
- o Antisocial Practices (ASP), Anger (ANG), and Cynicism (CYN) are elevated, this would confirm a cynical, angry, acting-out, and sometimes predatory individual.

- o When Type A Behavior (TPA) is also elevated, driven competitiveness can be readily turned into rage and aggressiveness toward others, especially if they perceive others interfering with their goal-oriented behavior.
- o When Antisocial Behavior (RC4) is elevated above Persecutory Ideas (RC6), these individuals are more likely to be critical, argumentative, and at increased risk for problems with substances. If RC6 is greater than RC4, expect suspiciousness and difficulty forming close relationships.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Male

Low 0 Father conflict, worries a great deal, aggressive or belligerent.

- Note: Scale 0 coded low was infrequently associated with worrying a great deal.

Low 1/2/3/5/ Worries a great deal.

Female

Low 0 Lacks academic drive, socially extroverted, resistant in the interview.

Low 1/2 Socially extroverted.

Low 5 Rebellious toward home, physical inferiority, indecisive, anxieties, lacks skills with the opposite sex.

Nothing Low Restless, 8+ conferences.

(Drake & Oetting, 1959)

o **Check:** *ANX, OBS, DEP, DEP1, DEP2, DEP3, DEP4, RC4, RC6, BIZ1, BIZ2, ANG1, ANG2, CYN1, CYN2, ASP1, ASP2, TPA2, SOD1, SOD2 (low), FAM1, FAM2, AGGR, PSYC, DISC, Dr1, Dr4, Dr5, Hy3, Pd1, Pd2, Pd3, Pd4, Pd5, Pa1, Pf1, Pf2, Pf3, Pf4, Pa2, Pa3, Sc1, Sc2, Sc3, Ma1, Ma3, Si1 (low), Si2, A, R, O-H, Re, MAC-R, AAS, MDS.*

TREATMENT

The 46 individual can be difficult to treat because they enter treatment defensively, and so tend to be argumentative, provoking anger or irritation in the therapist, confirming the 46 belief that they need to be defensive. In the interview situation, they might view the clinician's history taking as probing for what is "wrong with them," and so tend to be defensive. They have difficulty empathizing. When hurt, fearful, or angered, they express their feelings as a judgment or a subtle criticism of others. Rather than express their desires as requests, they frame them as owed demands. They have difficulty asking directly for what they want. Look for childhood conditioning experiences of

authoritarian, controlling caregivers who could use harsh punishments and judgment as a way to control them.

Harsh

criticism that often felt unfair and will-breaking punishments may have elicited from them the adaptive response of being cautious about being controlled, and approaching others with a wary defensiveness. They have difficulty being vulnerable and making requests, perhaps out of fear that to do so would give others control or power over them.

This profile has been described as the “chip on the shoulder” profile, reflecting their edgy irritability and argumentativeness, which is understandable as a defense against having been harshly criticized, judged, and humiliated as a child. Others see them as “itching for a fight” and respond defensively to them. Often they experienced the more severe conflict with the opposite sex parent.

Consequently, positive regard and trust building is needed before therapy can begin. Explaining to them how they have extremely high standards and tend to be their own worst critic could help them develop a sense of empathy for themselves as children who experienced unfair and unreasonable criticism and punishments, and tried to be above criticism. Help them understand how they adapted to early humiliations and unfair punishments by being constantly prepared to defend their emotional and personal boundaries. Use CBT to help them learn to ask for what they want before they become resentful. Help them verbalize their needs and emotional vulnerabilities without expressing them as somehow owed to them by others. Cognitive behavioral training, to help them verbalize their feelings without needing to explain why those feelings are reasonable, could help them understand why others respond defensively to them. Exploring any memories where they felt particularly unfairly treated can help them unblock some of their bottled up hurt and anger and, through catharsis, help them become more comfortable exploring their emotional vulnerability.

o **Treatment:** Motivation for change is typically low, especially in younger patients who view lost relationships as easily replaced. Motivation is higher in older patients who have gained at least some insight into the destructiveness and self-defeating nature of their behavior patterns, although they are at a loss to know how to change them. In either case, the manipulateness, provocativeness, and hostility of these patients, and their expectations of rejection, make their treatment stressful for the therapist. Successful treatment tends to be long term.

- Males with high 8s: psychotic, especially paranoid schizophrenic or prepsychotic; with 2 and/or 3 also elevated, the chances of a borderline condition are significantly increased. Will be angry and have significant conflicts relating to their own denied but strong needs for dependency, will rebel against authority figures, may use suicidal threats to manipulate others.

- Females: may be psychotic or prepsychotic but are more often passive-aggressive personalities; with high 3 they will have intense needs for affection and will be egocentric, demanding, but resentful of the demands placed on them by others.
(Groth-Marnat, 2009)

Treatment Implications

Persons with this profile are generally suspicious and even antagonistic toward treatment. When they do appear for treatment, it is at the insistence of someone else. As a result, they are mistrustful, suspicious, and project the blame for any difficulties onto someone else. Treatment plans should be concrete, clear, realistic, and described in a way that doesn't arouse suspicion or antagonism. A therapeutic relationship is difficult to establish and, once established, is likely to be somewhat turbulent. The possibility of angry acting out should be carefully monitored.

Therapy and Therapeutic Pitfalls

Rapport is developed by therapist acknowledgment and respect for these clients' self-protective vigilance against violations of their boundaries and personal space. Explain that their profile suggests they have been violated in the past and that their argumentativeness and suspiciousness makes sense given their childhood experiences. Describe how their angry argumentativeness was an adaptive response but that its continuation can create ongoing and unnecessary conflicts with others. Identify childhood moments when they felt attacked, criticized, judged, and unfairly treated. Revisit those episodes using gestalt therapy to assist them in expressing their rage at what they perceived as will-breaking punishment or criticism. Other therapeutic tools include role playing asking for what they want before feeling angry and resentful, helping them to identify feeling vulnerable when making demands on others in order to teach them to express their needs directly rather than expressing them as criticisms and rationalized demands. It is important to address transference, as the therapist is easily viewed as an unreasonable, arbitrary, and demanding authority figure. There is a tendency for them to withhold information. It can be productive for the clients to verbalize hurt or anger toward the therapist who can then role model vulnerability and apologize for hurting their feelings. A combination of insight, cognitive restructuring, catharsis, assertiveness training, and self-esteem building is suggested. Alcohol or drug abuse is common and needs to be addressed.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Treatment and Self-Help Suggestions

1. Explore with your therapist your childhood experiences of being unfairly treated. See if you can capture any particular memories of being controlled and criticized and what it felt like at the time, being unable to protect

yourself. Work with your therapist to become aware of your thoughts, feelings, body sensations, breathing, and posture as you re-experience those emotions of being unfairly criticized and rejected. The goal is to address unfinished feelings from the past that are causing you pain.¹

2. Determine what is trapping you currently. You may be in a situation that reminds you of how you grew up feeling criticized and unfairly treated. It may be hard for you to see a way out of your current predicament. First, determine what it is you want, and then see if you can honestly negotiate your needs with those around you. Remind yourself that your current feelings may make it hard for you to determine whether you're seeing people's motives clearly.

3. Resilience building: Explore your tendency to wait until you are "above criticism" before you make demands on others, and rehearse with your therapist how to express your thoughts and feelings without expressing them as blame or anger. Learning to assertively ask for what you want will do a great deal to alleviate your feelings of anger and blame and will give you a greater sense of self-control. Practice assertive requests with your therapist; role play situations where it is difficult for you to make requests in a reasonable way. Assertive statements begin with "I" (e.g., I want; I feel; I think), "When you" (e.g., make jokes; don't help with housework; have me work late hours), and, "I would appreciate it if you would in the future" (e.g., not make jokes at my expense; do the dishes every other night; give me advance warning when you want me to work late).²

4. Explore with your therapist any feelings you may have that your therapist is criticizing or judging you. It's important that you talk to your therapist about any feelings you have toward him or her so that you don't start withholding information, store up resentment, and turn things you don't like into excuses to leave therapy.

5. Learn to recognize when anger is building so you can express it before it becomes an enraged temper outburst. You may believe that it is "cathartic" to express your rage; there was a popular theory that anger was a physical energy that built up inside and if it wasn't expressed it could lead to physical health problems such as cardiac disease. In truth, the *expression* of hostility and rage turns out to be the real culprit in heart disease.³ "Venting" anger serves only to elevate blood pressure and makes us even more enraged; however, expressing anger in an assertive and direct way will lead to a reduction in anger and the corresponding physical symptoms.

6. You are a sensitive person, so your feelings can easily get hurt. See if you can identify any automatic negative thoughts that contribute to you feeling angry and resentful. Examples of automatic thoughts include *mind reading*, which is the belief that you know what others are thinking even though they haven't told you; *personalizing* by

investing innocuous events with personal meaning; or thinking in absolutes terms of should, must, ought, or have to. Once you notice any of these types of thinking, write them down, and work with your therapist to develop more constructive statements.

7. Examine with your therapist whether you are using chemical agents as a way of feeling better. Do alcohol or chemical agents get you in trouble with others? Are you more impulsive when you use them?

8. You may have worked so hard at being above criticism that you may be out of touch with what you really want and need. Start by identifying some basic wants: physical, emotional, spiritual, intellectual, and social needs. Do you want approval, help, more attention, to be listened to, respected? Work with your therapist to choose one or two areas that would be the most comfortable for you to work on.

9. You are sensitive to criticism, and sometimes you may find yourself feeling so on edge that you feel others are out to get you and harm you. You may then plan for ways to protect yourself or even to get vengeance. Explore with your therapist whether you are thinking clearly or whether your sensitivity has shaded toward paranoia.

1 Gestalt therapy techniques such as “empty chair” have typically been considered most effective with “overly socialized, restrained, constricted individuals” (clients such as the 4-6 who are resentful, irritable, and sensitive to criticism) whose constrained functioning is primarily due to “internal restrictions” (Fagan & Shepherd, 1970, pp. 234–35). There is empirical support for claims of the efficacy of the empty chair technique in resolving intrapsychic conflicts (Greenberg & Dompierre, 1981).

2 In a study of the control that language exerts over emotions and behavior, various types of assertive versus accusatory communications were examined. A total of 40 undergraduate women were asked to imagine discussing a relationship problem with their close partner and to rate their own reactions. Accusatory “you” statements elicited higher ratings of negative behaviors and emotions than did assertive “I” statements (Kubany, Richard, Bauer, & Muraoka, 1992).

3 High levels of Hostility (Ho) on the MMPI were associated with increased levels of coronary atherosclerosis. In one study, 255 medical students were assessed with the MMPI for levels of expressed hostility; 25 years later the most irritable subjects had nearly five times as much heart disease than their less angry counterparts (Barefoot, Dahlstrom, Grant, & Williams, 1983). Hostility is also associated

with a lower survival rate in clients with coronary artery disease (Boyle et al., 2004).
(Levak, Siegel, Nichols, & Stolberg, 2011)

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you are going through life feeling vulnerable to being criticized, judged, controlled, or unfairly treated by others. It is as if you anticipate that other people will make unreasonable demands on you, so you feel a need to protect yourself. Sometimes people with your profile grew up in an environment where a parent was demanding, controlling, critical, and even harshly punishing. From an early age you had to learn how to protect yourself, to argue your case, and be ready to protect yourself against unfair criticism and punishment. Currently you seem to be going through life as if anticipating judgments and criticisms. Consequently, it annoys you if others make demands on you, but you are sensitive to what others owe you. It is hard for you to ask for what you want directly as a request, perhaps because you're afraid that if you do so others will somehow have control over you. You dislike owing people anything, so you resist asking for what you need because it makes you feel vulnerable to their demands for reciprocation. You generally wait until you feel irreproachably justified before you're able to express your wants or your anger, by which time you are quite angry and resentful. By the time you express your feelings, you might feel a need to explain why your feelings are "just and right," and why you deserve to feel them. However, others may feel criticized or judged, feeling that you're explaining your emotions as somehow being their fault.

Inadvertently, you may end up causing just the kind of conflict you are trying to avoid. Because it is hard for you to trust others, you may feel the need to manipulate, tell white lies, or selectively report as a way of getting what you need. Talk to your therapist about any childhood experiences when you felt particularly criticized, judged, or unfairly punished. Get in touch with what that felt like, and allow yourself to have some empathy for yourself as a child. Practice ways that you can ask for what you want before you feel that you are owed it, so that you express your feelings without having to explain why they are justified or why someone else is wrong. Work at forgiving others when they have hurt you, even though your sensitivity makes you experience painful events intensely.

Practice assertiveness requests with your therapist, and role-play situations where it is difficult for you to make requests in a reasonable way. Make assertive statements that begin with "I" (e.g. "I want, I feel, I think"). Also, it is important that you talk to your therapist about any feelings you have towards him or her, especially if you feel in any way criticized or judged.

Feedback Statements—Elevated Profiles (T-Score > 65)

Strengths

You are a person with a number of psychological strengths. You are independent, rational, analytical, and you want to be fair-minded. You are loyal and self-reliant, and you think for yourself. Currently, you are going through life vigilant to make sure nobody invades your boundaries and takes advantage of you. You are sensitive to any demands placed on you, and you are quick to protect yourself from them.

Argumentative or Defensive

Because you are so vigilant for any demands placed on you, others may see you as defensive and argumentative. You're sensitive to what is yours and what others might take away from you, but others may see you as too quick to protect yourself and to demand things from others. They may see you as self-absorbed and slow to forgive. Growing up feeling unfairly treated and even judged and criticized, you became distrustful of others, afraid to let your guard down and be vulnerable in case others take advantage of you or hurt you in some way. Relationships, especially with close loved ones, tend to be difficult because you don't like to be vulnerable and let people get too close.

Sensitive to Being Controlled or Unfairly Treated

You're afraid that others will take advantage of you, use your vulnerability against you, and attempt to control or hurt you. When you care about someone, you feel especially vulnerable to being controlled, and that's when you can put up an angry, protective shield. You want others to show you loyalty and affection, yet you may find it difficult to be vulnerable and give back in your relationships, fearful that caring for others will make you feel vulnerable or weak. In relationships, you may feel you're not getting enough from the other person and that you are being unfairly or unjustly treated. If somebody treats you with disrespect or lies to you, you want to punish them.

Irritable or Slow to Forgive

Currently, you seem to be feeling on edge, irritable, and ready for battle. You are a sensitive person, and your feelings can be easily hurt. If people hurt or offend you, you feel obligated to punish them, pay them back, and teach them a lesson. It's hard for you to forgive them because it hurts so much, and you are afraid to trust them again.

Sensitive or Paranoid

You are quite sensitive to criticism, perhaps revealing how painful it was to be criticized as a child. When people criticize you now, you're ready to argue and to show them how they're wrong and what's wrong with them so that they back off. Perhaps this was the only way you could protect yourself as a child, arguing against an unreasonable and controlling authority figure. At times, your sensitivity may actually become a little paranoid, where it's hard

for you to know who you can trust.

Resentful or Demanding

You don't like to owe anybody anything because you are afraid of being controlled by them, so you tend to wait and not make demands on others until you feel you are completely justified in doing so. However, by that time you are often angry and resentful. As a result, when you ask for something, it may come across as demanding, as if other people owe you something, which leads to them feeling resentful, angry, and argumentative with you. As a child, you probably couldn't show vulnerability, and you couldn't ask for what you wanted without fear of some kind of reproach.

Substance Abuse or Acting Out

You may use chemical agents—alcohol or drugs—as a way to numb yourself or to feel better. You may be impulsive when stressed. Perhaps you will rashly express anger, use chemical agents, or even break the law. You can be quite vengeful if someone has hurt you, and if you use chemical agents your behavior can lead you into trouble with authority figures. If authority figures come across as controlling, you feel almost obligated to resist them on principle, even though to do so might lead you into more trouble. You may see your problems as due to unreasonable people who have treated you unfairly. If you get into trouble because of your behavior, you may feel some angry impulses toward yourself. At these times, you may engage in self-defeating or even self-destructive acts.

Lifestyle and Background Feedback

You are sensitive to any violation of your boundaries, as if you have been unfairly treated or somehow violated. Sometimes people with your profile grew up in environments where a parent had been very controlling, critical, judgmental, harshly punishing, and shaming. You attempted to deal with authority figures by protecting yourself, numbing yourself so that you wouldn't feel the pain, and being always ready to argue and protect yourself. No wonder that, growing up in this environment, you developed an edgy vigilance for anything that could be construed as a demand or a criticism. Now you're always ready to argue, to defend yourself, to plead your case, and to protect yourself from unfairness and control by others.

Normal-Range Feedback (T-Score 50 to 65)

Your profile is well within the normal range and reflects a number of healthy strengths. You test as a person who is independent and sensitive. You tend to draw on your own resources approaching problems in a nonconformist and innovative way. You work hard to be rational, fair, and analytical, and you try to avoid conflict where you could be

blamed. Presently, you are feeling cautious about being let down or unfairly treated. You are sensitive to anybody taking advantage of you, as you have likely felt unfairly treated or violated in the past. You are a person who values intimacy, but at the same time you are concerned about being controlled. You value independence and you resist authority figures that “come on too strong.” Although you can express anger in an appropriate manner, you also may store resentments and frustrations until you feel completely justified in expressing them, by which time you may be

resentful and you may have a difficult time forgiving others.

(Levak, Siegel, Nichols, & Stolberg, 2011)

462/642 Codes

The addition of Scale 2 to the 46/64 codetype adds feelings of being trapped, defeated, resentful, and, when depression is manifested, a negativistic anger and self-defeating, even self-destructive, behavior. The 462 individual feels wounded, hurt, unappreciated, and tends to be self-deprecating but, at the same time, demanding. These individuals allow others to make demands on them, but later feel used and unappreciated. Their depression is rationalized as due to other people and unreasonable circumstances, and as something that has been done “to them.” Symptoms of depression such as difficulties with sleep, loss of appetite, loss of sexual interest, and lowered efficiency and energy are typical. These individuals demand attention and sympathy because of their obvious hurt and resentment, but do not trust it when it is forthcoming. They tend to be demanding of others in subtle, guilt-inducing ways, which provokes anger in others. A possible diagnosis of borderline personality is associated with this codetype. Sexual marital maladjustment and conflicts are likely. Despite their difficulties trusting others and their resentment towards authority, they typically have an exaggerated need for affection and are dependent. They fear vulnerability and, because they crave reassurance, they often are angry with the person whose support they most covet. Interestingly, the 462/642 is often the youngest child in the family and their school achievement is below average (Marks and Seeman, 1963).

- o Hostility and depression often form a cyclical pattern with this profile. The expressions of hostility often lead to guilt, then anger reoccurs because of resenting the guilt feelings (Lachar, 1974).
- o Marks et al. (1974) found the 44-2/6-4-2 pattern in a university hospital and outpatient clinic. The pattern was primarily found for females. A woman with this pattern tended to be acting out, depressed, critical, and skeptical. The Marks, Seeman, and Haller book should be consulted for further information concerning this profile.

Diagnosis

Personality disorder 60%++	Passive-aggressive
Psychoneurosis 30%	Mixed
Psychosis 10%-	Mixed
Brain syndrome 0%	

Rules

- 4, 6, and 2 above 70 Ts
- 4 minus 2 less than 15 T-scores
- 4 and 6 greater than 8
- 4 greater than 7 (or 7 minus 4 less than 5 T-scores)
- 6 minus 2 less than 10 T-scores
- 7 greater than 8 (or 8 minus 7 less than 5 T-scores)
- 9 below 70 Ts
- L and K less than F, F below 80 Ts

Most Descriptive

- 14. Utilizes acting-out as a defense mechanism (8.6)
- 34. Undercontrols own impulses; acts with insufficient thinking and deliberation (8.6) + +
- 79. Is resentful (8.6) +
- 98. Is egocentric; self-centered ; selfish (8.4) + +
- 75. Has inner conflict about emotional dependency (8.2) +
- 17. Utilizes projection as a defense mechanism (8.0) +
- 52. Is self-dramatizing; histrionic (8.0) + +
- 65. Has an exaggerated need for affection (8.0) +
- 84. Is critical; not easily impressed; skeptical (8.0) + + +
- 89. Is provocative (8.0) +
- 64. Expresses impulses by verbal acting-out (7.8) + +
- 70. Utilizes rationalization as a defense mechanism (7.8) +
- 73. Is excitable (7.8) + +
- 78. Is irritable (7.8) +
- 83. Is argumentative (7.8) +

- 97. Is sensitive to anything that can be construed as a demand (7.8) +
- 39. Genotype has psychopathic features (7.6) + +
- 44. Is distrustful of people in general; questions their motivations (7.6) +
- 72. Is demanding; tends to take the attitude "the world owes me a living" (7.6) +
- 2. Demands sympathy from others (7.4) +
- 5. Possesses a basic insecurity and need for attention (7.2)
- 77. Is tearful and/or cries openly (7.2) +
- 93. Exhibits depression (manifest sad mood) (7.2)
- 22. Resents authority figures and typically has impulses to resist or derogate them (7.0) +
- 80. Emphasizes oral pleasures; is self-indulgent (7.0) +
- 96. Genotype has paranoid features (7.0)

Least Descriptive

- 49. Appears to be poised, self-assured, socially at ease (1.2) —
- 63. Has a resilient ego-defense system; has a safe margin of integration (1.2)
- 91. Tends toward overcontrol of needs and impulses (1.2)
- 95. Accepts others as they are; is not judgmental (1.8) —
- 30. Has "diagnostic" insight; awareness of the descriptive features of own behavior (2.0) —
- 51. Exhibits good heterosexual adjustment (2.0) —
- 67. Is able to sense other person's feelings; is an intuitive, empathic person (2.0)
- 107. Would be organized and adaptive when under stress or trauma (2.0)
- 69. Gets along well in the world as it is; is socially appropriate in own behavior (2.2) —
- 86. Is shy, anxious, and inhibited (2.2)
- 11. Is cheerful (2.4)
- 42. Is "normal," healthy, symptom free (2.4) +
- 105. Manifests hypochondriacal tendencies (2.4) —
- 9. Presents self as being physically, organically sick (2.6)
- 41. Has good verbal-cognitive insight into own personality structure and dynamics (2.6)
- 37. Defenses are fairly adequate in relieving psychological distress (2.8) +
- 90. Is apathetic (2.8)
- 4. Has a need to think of self as an unusually self-sufficient person (3.0)
- 12. Tends not to become involved in things; is passively resistant (3.0)

- 31. Has a high aspiration level for self; is ambitious; wants to get ahead (3.0)
- 45. Thinks and associates in unusual ways; has unconventional thought processes (3.0)
- 48. Fears loss of control; cannot "let go" even when appropriate (3.0)

Personality Description

The characterization of these patients as depressed is consistent with the elevation of scale 2 in the profile. This depression is manifested in open tearfulness, negativism, and in suicidal threats and attempts. Nevertheless, it is the characterological features of these patients rather than their depressive mood which dominate the psychological picture and which present a striking contrast between the 4-6-2 type and other depressed patients (e.g., the 2-7 or the 2-3-1 types). The central personality traits are consistent with the basic character of the constructs underlying scale 4 and scale 6. It is interesting that clinicians characterize these patients as "psychopathic" (consistent with scale 4) and as "paranoid" (consistent with scale 6). Correspondingly, the defense mechanisms of rationalization and projection are rated as typical of the operating style exhibited by these patients.

The 4-6-2 patients' lack of ego control of impulses-leading to hasty, impulsive, and thoughtless action, is also consistent with the underlying scale 4 construct. These people project a self-dramatizing, histrionic quality. They convey the impression of egocentricity, and are seen as self-centered, and self-indulgent. They are given to forceful comments and assertions, sometimes very provocative. Adjectives often ascribed to them are resentful, irritable, excitable, and argumentative. They rate generally low in trust of others and tend to question their motivations. The underlying rebelliousness of scale 4 is reflected in the consistent resentment manifested with respect to authority figures and a tendency to derogate them. They are critical, skeptical, and not easily impressed as well as sensitive to anything that might be construed as a demand. Consistent, too, is the "acting out" of conflicts by these patients in impulsive and antisocial ways; if, in a loose sense, one may talk meaningfully about the locus of psychopathology-then it might be said that in the 4-6-2 patient the locus is in the behavior rather than in the mental or physical domain. They undercontrol their impulses and act without sufficient foresight or deliberation.

One psychodynamic view of the kind of aggressive or passive-aggressive behavior characteristically displayed by these patients is that such behavior is essentially a defense against inner conflict revolving around strong dependency needs. Whatever the status of the theory, it remains an empirical fact that clinicians consistently judge these patients to be suffering from such conflict about emotional dependency. Correlated with this are feelings of basic insecurity, excessive needs for attention, exaggerated needs for affection, and a generally demanding orientation ("the world owes me a living"). These patients are often the "baby" of the family. Although their school

achievement is typically below average, 32% of them eventually receive a college education. Eighty-four per cent are married and there is conflict in 82% of these marriages. One in six of these patients has an alcoholic and/or mentally ill father.

Nevertheless, paternal relations during childhood are described as having been affectionate (60%), while maternal relations were described as having been indifferent or rejecting (67%). Both parents are typically said to have been permissive.

TREATMENT

Look for childhood experiences of an unavailable caretaker, perhaps due to chemical abuse. Also look for childhood experiences of caregivers being unfair, controlling, arbitrary, and punishing. Treatment should focus on the current, perceived entrapping situation and help the individual problem solve without being dependent or passive-aggressive. In some cases antidepressant medication may be useful to alleviate the depression. CBT may help them be more assertive and help them to understand how they are self-effacing and, at the same time, resentful that they are not recognized. One example of a 462 individual is a woman who was the oldest of nine children. She felt responsible for her siblings, as her mother was emotionally unavailable, and she tried to please her father by keeping the house clean. The siblings would rarely assist her, and she felt constantly, unfairly burdened. Her father would occasionally blow up at her for not keeping the house clean and did not recognize her efforts. As an adult nurse, she would volunteer for duties and responsibilities that were beyond her job description. She felt unappreciated at work and was resentful, but was also afraid to stand up for herself and continued to take on responsibilities, even when she was not asked to do so. The cycle of hurt, resentment, feeling unappreciated, and burdened, and yet being frightened to assert her wants, is a good example of the 462 individual.

THERAPEUTIC FEEDBACK LANGUAGE

Also look at 46, 24, and 26 feedback statements. Your profile suggests that you are currently feeling trapped, maybe bitter and resentful. Perhaps you have experienced some recent stress where you felt unfairly treated and you feel that you can't find a way to get your needs met. You may be experiencing some symptoms of depression, feeling sad, unhappy, low energy, and with difficulties with sleep and general efficiency. Talk to your therapist about whether you are feeling currently trapped and resentful, and practice assertiveness training so you can verbalize what you need without others feeling criticized or judged.

463/643 Codes

The addition of Scale 3 to the 46/64 codetype suggests control over the expression, and limited awareness of hostile and resentful feelings. At the same time, the Scale 3 attributes suggest a need for more interpersonal connection and approval. The 463 individual can appear charming, even seductive, and often role-plays correct social roles with hostility masked by a veneer of public correctness. The elevation of each scale in relation to the others is relevant. If the codetype is primarily a 46/64 with Scale 3 coded third and significantly lower than either Scale 4 or 6, then the classic 46/64 code attributes will be evident. Edgy suspiciousness, oversensitivity, and argumentativeness are poorly asked by Scale 3 defenses. However if Scales 4, 6, and 3 are all elevated at about the same level, then the individual presents with a good social front, conforms to role expectations, and appears socially correct, poised, and self-controlled. Anger, oversensitivity, and resentment are expressed in circuitous, perhaps sarcastic ways, as subtle judgmentalness, a sensitivity that can shade towards paranoia and a quickness to feel hurt and rejected. 463 individuals have difficulty with the constructive expression of rejection of others, projecting their own sensitivity, and avoiding conflict until resentments accumulate. When angered or feeling unfairly treated, they tend to pursue retribution with controlled, rationalized vigor. They are very sensitive to any slights or injustices they feel perpetrated against them. Anger can be particularly focused on family members and is often highly rationalized and overly justified. This profile has been associated with individuals involved in long and bitter divorce custody battles (Caldwell, 1997). As one would expect with the elevation on Scale 3, these people have difficulties with the expression of anger. Anger tends to be expressed as judgment and blame of others, and is highly rationalized. If the *O-H* scale is elevated, they may then show infrequent, brittle, angry eruptions that are justified as self-protective. They often repress the memory of the intensity of their anger and the things they say when angered, and lack empathy for those targeted by it. Individuals with this profile generally conform to role expectations, subtly resist authority, and resent being controlled. They can also evidence paranoid mistrust of others, reflecting their tendency to role-play, which they also expect from others. They take things personally and can easily feel jealous and possessive, but rarely acknowledge such feelings, since it would leave them open to criticism. Controlled, poised (especially if *L* and *K* are high), and observant of social etiquette, they play the correct role and subtly act out. They demand affection and attention, yet tend to distrust it when given, so others find the 463 individual hard to please. While wanting affection and approval, their edgy vigilance for being criticized, let down, or being controlled is self-defeating, as others withhold their approval in response. They aggravate others into expressing the anger and rejection that the 463 individual expects from them. They are often seductive with the opposite sex. Marital maladjustment is likely. Physical complaints reflecting over-control, sexual dysfunction, headaches, and backaches are also associated with this codetype.

TREATMENT

The 463/643 codetype reflects an individual who craves attention and affection, yet distrusts its sincerity when they obtain it. This reflects childhood experiences of being harshly criticized and rejected by a displeased caretaker.

Demands for strict conformity to appropriate social roles and values, and will-breaking rejections and criticisms for misbehavior would have led to the adaptive response of constantly playing a role to fit into others' expectations and therefore avoid rejection. During psychotherapy, they have difficulty expressing socially unacceptable impulses, often denying such feelings even when they appear to be expressing them. Help them to express anger as they become aware of it, rather than waiting until they feel justified before expressing it, by which time they are resentful and bitter. Have them role-play asking for what they want without using moral judgments. For example, have them repeat the phrase, "I would like you to give me ...," without having to justify it. Their defensiveness reflects childhood experiences of feeling criticized and judged, so they adapted by first justifying requests. Catharsis and insight therapy can be useful with these individuals, who tend to be quite rational and hyper-analytical.

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you have very high personal standards, and for you there is a right way and a wrong way of doing things. You go through life trying to fit in to others' expectations because it is painful for you if people are critical or judgmental of you. You have a rich mixture of personality traits. On the one hand, you want to follow the rules and do the right thing, and social etiquette is important to you. At the same time, you dislike being controlled and are careful about letting down your guard and letting people too close in case you get hurt or rejected.

Consequently, people with your profile often have friends who reflect different sides of your own personality. For example, you may have a socially conforming and traditional group of friends, and you also may have some friends who are more nonconformist. People with your profile often had parents who could be critical, judgmental, and rejecting when angered. From an early age you learned to play a role and do what was expected of you to avoid judgment and rejection. Perhaps you learned that you had to tell white lies in order to protect yourself. Perhaps that's why you developed an ability to conform, but at the same time, bend the rules. Because it was painful when you felt criticized or rejected, it is now hard for you to reject others unless you feel they deserve it. In fact, you may hold in negative emotions for long periods of time, wanting to be above criticism and wanting to make sure that your feelings are justified and fair. However, this may lead to anger and a buildup of resentments, so that when expressed, they come out in brittle, explosive ways. Work with your therapist to explore childhood experiences when you felt criticized and rejected. Learn to ask for what you want before you end up feeling resentful, and avoid telling people what they have done wrong. Try making "I" statements, rather than justifying your feelings based on others'

bad behavior. Learn to integrate the conforming and nonconforming sides of you. Avoid selectively reporting as a way to avoid conflict.

465 Code

(See 4-6 point 10.)

Wives who are in marriage counseling have a higher proportion of this profile pattern than do wives from the general population (Arnold, 1970; O'Leary et al., 1983).

467 Code

Male

Low 0 Introverted or self-conscious or socially insecure, home conflict, father conflict, one interview only, worries a great deal, lacks knowledge or information, aggressive or belligerent.

- Note: Scale 0 coded low was infrequently associated with worrying a great deal.

Low 1 Introverted or self-conscious or socially insecure, home conflict, nonresponsive or nonverbal, worries a great deal.

Low 2/3/5/8/9 Introverted or self-conscious or socially insecure, home conflict, worries a great deal.

Nothing Low Introverted or self-conscious or socially insecure, lacks skills with the opposite sex, home conflict, mother conflict, sibling conflict, nonresponsive or nonverbal, tense, indecisive, unhappy, worries a great deal, insomnia, confused, poor rapport.

- Note: Scale 4 coded high was infrequently associated with lack of skills with the opposite sex.

Female

Low 0 Insomnia, rebellious toward home, socially extroverted, lacks academic drive, resistant in the interview.

Low 1/2 Insomnia, rebellious toward home, socially extroverted.

Low 3 Insomnia, rebellious toward home, cried in the interview.

Low 5 Insomnia, anxieties, headaches, exhaustion, nervous, rebellious toward home, lacks skills with the opposite sex, socially insecure, indecisive, physical inferiority, lacks self-confidence.

- Note: Scale 3 coded high was infrequently associated with social insecurity.

Low 8/9 Insomnia, rebellious toward home.

Nothing Low Insomnia, restless, headaches, rebellious toward home, sibling conflict, tense on examinations, 8+ conferences.

(Drake & Oetting, 1959)

468/648 Codes

This codetype suggests a severe and sometimes chronic disorder. Sometimes the profile is associated with a thought disorder diagnosis. These individuals are alienated, deeply resentful and suspicious of others, and are often defensively hostile. Some may show antisocial personality traits. They are hypersensitive, critical, argumentative, and evasive. Extreme sensitivity can shade to paranoid ideation. They are easily hurt by criticism, and can experience breakdowns in reality testing. They ruminate about real or imagined threats and injustices, and may show delusions or ideas of reference. Grandiosity may be present. Primary defenses are acting out, projection, reaction formation, and rationalization. Anger and rage are often rationalized as self-protective. Although complaints of depression are associated with this codetype, apathy and emotional alienation from self and others may be contributing factors. Poor judgment, lack of insight, and impulsive angry episodes are typical. In some cases, these individuals can be assaultive. They often abuse chemical agents, which would aggravate impulsive behavior and breakdowns in reality testing. Threats of suicide or violence toward others should be taken seriously. Problems in interpersonal, marital, and sexual adjustment are common. If *K* is below *T*-50, the propensity to impulsively act out increases. If Scale 9 is also above *T*-65, the likelihood of acting out also increases. However, with elevated *K* and *Es* the paranoid anger can be more effectively masked and is therefore potentially more dangerous because of being less immediately obvious.

o 4-6-8/4-8-6/6-4-8/6-8-4/8-4-6/8-6-4

o Alienated, suspicious, depressed, hopeless, and hostile. Thought disorder, with derailment, tangentiality, and circumstantiality; paranoid symptoms are common, as are anxiety and depression. Depression tends to be partially externalized and expressed in apathy, tension, and agitation; attitudes of hopelessness, worthlessness, and helplessness; and suicidal ideation. Thinking and behavior are often disorganized. May be unpredictably assaultive. See 4-6/6-4, 4-8/8-4, 6-8/8-6. This codetype is discussed in Graham et al. (1999).

1. A person with a 4-6-8 pattern may be brought in for help by someone else. He/she usually has symptoms of seething anger. Prognosis is poor because the person tends to want his/her problems solved by having other people change (Caldwell, 1972).
2. This is an adverse pattern for most short-term therapy.

3. Anderson and Holcomb (1983) have found this pattern aF one of five in a group of accused murderers. This group of murderers had paranoid personalities or were sociopaths with bad judgment. They were also the group with the highest intelligence. They resembled Megargee and Bohn's (1979) Foxtrot pattern.

Male

Low 0 Father conflict, worries a great deal, lacks knowledge or information, aggressive or belligerent.

- Note: Scale coded low was infrequently associated with worrying a great deal.

Low 1/2/3/5 Worries a great deal.

Low 9 Worries a great deal, introverted or self-conscious or socially insecure.

Nothing Low Worries a great deal, imhappy, insomnia, confused, indecisive.

Female

Low 0 Depressed, insomnia, overprotective mother, socially extroverted, lacks academic drive, resistant in the interview, verbal, 8+ conferences.

Low 1/2 Depressed (48), insomnia, overprotective mother, socially extroverted, 8+ conferences.

Low 3 Depressed, insomnia, overprotective mother, 8+ conferences.

Low 5 Depressed, insomnia, anxieties, overprotective mother, rebellious toward home, lacks skills with the opposite sex, distractible in study, physical inferiority, indecisive, 8+ conferences.

Low 7/9 Depressed, insomnia, overprotective mother, 8+ conferences.

Nothing Low Depressed, insomnia, headaches, restless, overprotective mother, mother conflict, father conflict, sibling conflict, lacks skills with the opposite sex, 8+ conferences.

(Drake & Oetting, 1959)

TREATMENT

This is a difficult codetype to treat because the individual is vulnerable to paranoid ideation and often feels angry, resentful, and suspicious of others. These individuals show deficits of empathy and feel emotionally isolated.

Supportive non-confrontational psychotherapy is required for the development of trust. Therapists should maintain a

professional but open demeanor toward the patient, avoiding being overly friendly. Help them identify and vent any injustices and hostilities they feel have been directed against them. Because of their extreme distrust, empathy from the therapist must be authentic and not role-played.

Look for childhood conditioning experiences of being treated with hostility, physical abuse, cruelty, and rejection leading to the adaptive response of constant vigilance and self-protective cruelty toward others. The expression of hurt and resentment can be helpful in a controlled, structured manner, but it can also have a disorganizing effect on them. Helping them to develop better emotional regulation using CBT could be useful. It is important for the therapist to manage any anxiety that these individuals may elicit in them. If the therapist can remain unintimidated by the individual's bristling anger, and able to validate the patient's feelings as understandable given the abuse and mistreatment they experienced, then rapport can develop. Medication is often indicated, but rapport needs to develop before it is suggested.

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that currently you are vulnerable to feeling criticized, judged, or even attacked. Perhaps others have mistreated you and you are therefore vigilant to maintain your self-protective guard. People with your profile sometimes grow up with a parent figure that was rejecting, hostile, or even cruel to them. From an early age you may have learned to protect yourself by keeping people at a distance, or by being cruel or angry toward them before they could hurt you. Currently you may be feeling unfairly treated, angry, resentful, and vigilant for anything that can be taken as criticism or judgment from others. You may be feeling so vulnerable that it is hard to know whom to trust. At times you may get confused about what is real, wondering whether you are seeing reality clearly. Perhaps recently you've experienced hostility from others and now feel extremely vigilant and self-protective. At times, you may even feel paranoid. When stress builds, you may find yourself unable to stop your imagination invading your mind with disturbing thoughts. You may have used chemical agents to try to feel better, which would probably aggravate your tendency to be impulsive and act out some of your anger. Rehearse with your therapist situations when you feel threatened, and anticipate how you can avoid feeling out of control and confused. Find alternative ways to deal with your emotions rather than acting out by becoming angry, argumentative, or hostile with people. Avoid chemical agents, which may increase your tendency to be destructive and impulsive.

469 Code

See 496/946 Codes.

- o 4-6-9/4-9-6/6-4-9/6-9-4/9-4-6/9-6-4

- o Psychopathic and paranoid trends with brittle controls, rigidity, egocentricity, impulsiveness, hostility, hypersensitivity, resentment, suspiciousness, jealousy, and vindictiveness. Highly rationalized and externalizing.

Hyperarousal may lead to sudden and explosive violence, but sufficiently organized to plan and coldly carry out dangerous violence on others. Look for homicidal ideation.

Check: *AGGR, RC9*. See 4-6/6-4, 4-9/9-4, 6-9/9-6.

- o This is one of the most dangerous profiles for the potential to act out against others (Tromboli & Kilgore, 1983).
- o This pattern is found in people who suddenly are violent (Carson, 1969). This is especially true if scale 8 is elevated also.

Male

Low 0 Father conflict, worries a great deal, aggressive or belligerent.

- Note: Scale coded low was infrequently associated with worrying a great deal. This pattern was infrequently associated with introversion of selfconsciousness or social insecurity, shyness in the interview, being nonresponsive or nonverbal, being nonverbal or a nonrelator, indecisiveness.

Low 1/2/3/5/7/8/Nothing Low Worries a great deal

Female

Low 0 Vague goals, lacks academic drive, marriage oriented, verbal, resistant in the interview, home conflict, socially extroverted.

- Note: Scale coded low was infrequently associated with home conflict.

Low 1 Vague goals, verbal, home conflict, socially extroverted.

Low 2 Vague goals, verbal, home conflict, socially extroverted.

- Note: Scale 2 coded low was infrequently associated with home conflict.

Low 3 Vague goals, verbal, home conflict, socially extroverted.

Low 5 Vague goals, verbal, home conflict, rebellious toward home, socially extroverted, lacks skills with the opposite sex, indecisive, physical inferiority, anxieties, exhaustion.

Low 7/8 Vague goals, verbal, home conflict, socially extroverted.

Nothing Low Vague goals, verbal, 8+ conferences, home conflict, socially extroverted, restless.

47/74 Codes

Code-Type 4-7/7-4

Descriptors

Complaints

Anxiety, tension, guilt, impulsive acting out, addictive behavior, family discord or alienation, agitation, dysphoria, self-criticism, irritability

Thoughts

Ambivalent, manipulative, compulsive, anxious, guilty, self-critical, self-indulgent

Emotions

Anxious, guilty, tense, irritable, dysphoric

Traits and Behaviors

Cyclical acting out followed by guilt and anxiety, dependency/independency conflicts, anxious about security in relationships, conflict between compulsive acting out and anxiety and guilt, insecure

(Levak, Siegel, Nichols, & Stolberg, 2011)

Therapist's Notes

In the normal range these clients have a tendency to become anxious and, as tension builds, to act out impulsively. They avoid conflict and procrastinate in dealing with difficult situations. Their impulsive tension reduction can be

self-defeating, and although they experience guilt and self-doubt after acting out they tend to continue to do so. At higher elevations, the 4-7 code types reflect a more destructive approach—avoidance paradigm. Scales 4 and 7 reflect, in many ways, contradictory and polar opposite traits. Scale 4 predicts emotional alienation, self-centeredness, callousness, acting out, and poor impulse control. Scale 7 reflects anxiety, guilt, remorse, hyper-responsibility, and a desire for connection and reassurance. When elevated together, individuals are conflicted between needs for autonomy and immediate impulse gratification on the one hand and preoccupation with guilt, anxiety, and others' disapproval on the other. This tension results in episodic acting out followed by guilt, self-deprecation, and anxiety, leading to future cycles of tension and acting out. Their remorse, guilt, and fear of loss of love and approval after acting out are sincere at the time but diminish as tension and pressure build, lowering the threshold for acting out in the future. 4-7 individuals seek and ask for reassurance, emotional connection, and approval, yet they have difficulty with trust and emotional vulnerability. Accordingly, reassurance from others works only temporarily and needs to be constantly renewed. They find commitment particularly difficult, tend to push others away emotionally, and then panic when the other person withdraws. This can be frustrating and stressful to their significant others, who are alternately engaged into the relationship and then pushed away.

The 4-7 individuals have little awareness of the source of their conflicts. As is typical with Scale 4 elevations, they externalize blame, tending to see their anxiety as due to outside events, external circumstances, or other people's behavior. Others see them as quite self-centered, not only because they come across as demanding but also because they appear to lack empathy for others. Whether they are in an anxious, clinging, reassurance-seeking mode or acting-out mode, they tend to demand attention and affirmation from others. Often they need rescuing from the binds they find themselves in, whether legal, financial, or interpersonal.

As anxiety and tension build, they can become quite agitated, dysphoric, irritable, and prone to impulsive behavior. Their acting-out behavior may be antisocial (shoplifting), self-defeating (binge-eating), or destructive (gambling, infidelity, or some other form of instant gratification). They then feel guilty, remorseful, and self-critical. They can be quite manipulative, especially if other scales such as Ego Strength (Es) and K are elevated. With high 4-7 elevations and low K and Es, the ability to tolerate anxiety and control impulsiveness long enough to be effectively manipulative is reduced, and they cannot delay gratification easily.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Lifestyle and Family Background

Our hypothesis is that the 4-7 code types reflect insecurely attached individuals who have adapted to highly inconsistent parents who were indulgent and co-dependent but also controlling, unreliable, and perhaps explosive or rejecting. We hypothesize that the 4-7 individuals have a fear of unpredictable emotional abandonment.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Elevations on Scale 4 and 7 appear contradictory. Scale 4 predicts rebelliousness, acting out, deficits of empathy, and anger toward authority figures, whereas Scale 7 elevations suggest acquiescence, concern about others, guilt, anxiety, and hyper-responsibility. The 47/74 expresses these contradictory traits in a number of ways. In some cases the individual experiences periods of intense anxiety followed by impulsive tension reduction through acting out, followed by intense guilt. In other cases the 4–7 interactions are manifested as chronic approach avoidance ambivalence in many areas of their life. The presenting complaint for the 47 individual tends to be of anxiety and depression. These individuals demand reassurance from others, although reassurance tends to have little long-term soothing effect because of the mistrust associated with Scale 4. This codetype predicts cyclical acting-out behavior. As tension and anxiety build and stresses accumulate, these individuals impulsively reduce tension, usually in self-defeating ways. The resulting consequences create more anxiety, guilt, and self-recrimination, beginning a cycle of anxiety that again leads to impulsive tension reduction. In some cases, the acting out can be compulsive, such as bulimic purging, shoplifting, binge drinking, and sexual addictions, which represent the reduction of tension by impulsive ego-gratification, followed by guilt and anxiety. Typically, others see these tension-reducing behaviors as self-indulgent and self-defeating. As one would predict with elevations on Scales 4 and 7, these individuals exhibit intense conflicts between their dependency needs and their fears of being controlled. Although they can be compulsively demanding of reassurance, they rarely profit from it. These individuals have low tolerance for frustration and have difficulty persevering toward long-term goals.

o Alternates between periods of gross insensitivity to the consequences of own actions and excessive concern about the effects of own behavior; episodes of acting---out followed by temporary guilt and self--- condemnation; vague somatic complaints; tense, fatigued, exhausted; dependent, insecure; requires almost constant reassurance of self---worth; in therapy responds symptomatically to support and reassurance

Individuals with this high point pair show numerous characterological difficulties as well as cyclical patterns of acting out followed by periods of guilt, regret, and remorse for having done so. This guilt is usually out of proportion to the actual acting-out behavior and frequently is accompanied by somatic complaints. While such clients appear to be over-controlled, these controls are not sufficient to prevent recurrences of acting-out behaviors and gross insensitivity to the consequences. Episodes of acting out may include excessive alcohol consumption, drug abuse, and sexual promiscuity. Individuals with this high point pair find rules, regulations, and limits imposed by others to be quite irritating and anxiety provoking. Though quite concerned with their own feelings and problems,

they are markedly callous and indifferent to the needs and feelings of others. Psychotherapy may prove effective, as such clients seek help when their guilt is most pronounced. However, the long-term prognosis is guarded.

Symptoms and Behaviors

Persons with high scores on Scales 4 and 7 experience guilt over their behavior, and are brooding and resentful. Although they are frequently insensitive to the feelings of others, they are intensely concerned with their own responses and feelings. They justify this insensitivity because they feel rejected or restricted by others. Their behavioral and interpersonal difficulties follow a predictable cycle in which they will alternately express anger and then feel guilty over their behavior. While they feel angry, they may have little control over their behavior, which results in impulsive acting out (check the ASP/Antisocial Practices and ANG/Anger scales). This is followed by a phase of excessive overcontrol accompanied by guilt, brooding, and self-pity (check the O-H/Over-Controlled Hostility scale). Frustrated by these feelings, they may then attempt to selfishly meet their needs through means such as alcohol abuse, promiscuity, or aggressive acting out. Thus, the cycle continues and is usually fairly resistant to change. This frequently leads to legal problems and to difficulties in their work and home relationships. Although they do feel genuine and even excessive guilt and remorse, their self-control is still inadequate and their acting out continues.

Diagnostically, the 47/74 type is most likely to be either an antisocial personality or an anxiety disorder. This profile is frequently seen in alcohol, drug (check the MAC-R, AAS/Alcohol Acknowledgment, or APS/Alcohol Potential scales), or other treatment settings to which individuals with impulsive-compulsive styles are referred (e.g., eating disorder programs for persons with bulimia).

Personality and Interpersonal Characteristics

Core difficulties relate to feelings of insecurity and ambivalence regarding dependency. Clients need frequent reassurances that they are worthy.

o A recurrent cyclical pattern of impulsive acting out to relieve tension followed by periods of self-recrimination and self-control. Both phases characterized by compulsive elements (e.g., binge drinking followed by periods of sobriety enforced by compulsive means). Anxiety, tension, agitation, and turmoil, with dysphoria, guilt, remorse, and exaggerated self-criticism during periods of relative behavioral control. Impulse ridden. Low tolerance for frustration. Poorly consolidated conscience. Acts out in self-defeating ways; repeatedly sacrifices long-term goals for momentary tension reduction. Chronic dependency/independency conflicts; strong need for affection and security in relationships. Easily angered when frustrated or denied dependency gratifications. Cyclical pattern

is also evident in relations with others, with periods of reckless disregard for the needs and feelings of others followed by abject efforts at reparation and reconciliation. Exploits others to gratify dependency needs; intermittently very fearful of the withdrawal of love and support. Look for a history of substance abuse, arrests for intoxication, compulsive gambling, sexual promiscuity/infidelity, employment instability, and marital conflict.

This code group shows an interesting internal contradiction in self-description; 47's indicate both excessive insensitivity in scale 4 and excessive concern about the effects of their actions in scale 7. This psychological contradiction frequently appears behaviorally as an alternation of phases or cyclical variations. For a period these persons may act with little control or forethought, violating social and legal restrictions and trampling on the feelings and wishes of others heedlessly. Following such a period of acting out, however, they may show guilt, remorse, and deep regret over their actions and for a while seem overly controlled and contrite. Excessive alcoholic indulgence may be a part of these activity swings, as well as other amoral activities. While their conscience pangs may be severe, even out of proportion to the actual behavior deviations, the controls of these subjects do not appear to be effective in preventing further outbreaks. Guthrie described a small group of women with this code pattern who consulted an internist. When seen by the physician they were tense and suffering from fatigue and a number of vague symptoms like headache, loss of pep, or pains in the stomach. They appeared to be dependent and insecure, requiring a great deal of reassurance. They had histories of family rejection or overindulgence. Although the number of visits made to the physician was above average, they obtained very little benefit from the simple reassurance or physical treatment given.

Data on the 472 pattern are reported by Marks and Seeman (see Chapter 3 for the defining characteristics of the 247-472 pattern).

Persons with the 47/74 code type may alternate between periods of gross insensitivity to the consequences of their actions and excessive concern about the effects of their behavior. Episodes of acting out, which may include excessive drinking and sexual promiscuity, may be followed by temporary expressions of guilt and self-condemnation. However, the remorse does not inhibit further episodes of acting out. 47/74 individuals may present vague somatic complaints, including headaches and stomach pain. They also may report feeling tense, fatigued, and exhausted. They are rather dependent, insecure individuals who require almost constant reassurance of their self-worth. A diagnosis of passive-aggressive personality disorder often is given to persons with the 47/74 code type. In psychotherapy they tend to respond symptomatically to support and reassurance, but long-term changes in personality are unlikely.

1. People with this pattern tend to have repeated patterns of acting out and then being sorry for the acting out (Hovey & Lewis, 1967).
2. While they may be very remorseful about acting out, this remorse is not usually sufficient to prevent them from acting out again (Dahlstrom et al., 1972).
3. These people have both excessive insensitivity and excessive concern about their actions. This may be cyclical (Lachar, 1974).
4. These people may respond to therapeutic support, but they are unlikely to make long term changes in their personality (Graham, 1977).
5. Adolescents in treatment with this profile 4-7/74 (Marks et al., 1974) acted out, were provocative, resentful, and basically insecure. They had many friends but few close ones. The Marks, Seeman, and Haller book should be consulted for further information concerning this pattern.
6. Kelley and King (1979a) found the 4.7/7-4 profile code in a college counseling center. Clients with this profile were immature, moody, and reported feelings of inferiority, ruminations, and gastrointestinal problems.

Description:

Insensitivity and social alienation may cycle with moodiness and exaggerated interpersonal sensitivity, family problems, counterphobic sexual deviation

Possible Diagnoses:

Substance abuse, Bipolar/Cyclothymic dis.

Modifying Scales

- o When Scale 2 is elevated, look for despondency, guilt, and periods of immobilizing depression, especially after acting out. The 4-7-2 clients have a great deal of difficulty making decisions and are very ambivalent about commitment and intimacy.

- o When Scale 8 is elevated (4-7-8/4-8-7), there is more cognitive disruption and greater emphasis on the avoidance aspect of the approach–avoidance conflict with even more difficulties trusting others. Their damaged self-esteem tends to render their acting out more self-destructive, self-defeating, and sometimes cruel to others.
- o When Family Discord (Pd1) is elevated but Authority Conflict (Pd2) is within the normal range, then the acting out would likely be manifested in family conflict and alienation rather than in antisocial acting-out behavior. This would be especially true if Family Problems (FAM) was elevated but Antisocial Practices (ASP) ASP was not. However, if is elevated, then look for acting-out behavior that leads to legal difficulties and conflicts with authority figures.
- o When Anger (ANG) is elevated, the episodic accumulations of tension and anxiety or blocked demands would dispose them to angry outbursts when frustrated.
- o Typically Anxiety (ANX) and Low Self-Esteem (LSE) would be elevated, reflecting the apprehension and low self-worth associated with impulsive acting out.
- o When Obsessiveness (OBS) is elevated, look for obsessive ruminations about acting out and then agonizing about the extent of the damage and the possible consequences.
- o When Fears (FRS) is elevated, clients may exhibit specific fears and phobias that are iconic of the approach–avoidance conflict. For example, a fear of bridges or heights might symbolize their low impulse control when confronted with situations without boundaries.
- o When Type A Behavior (TPA) is elevated, the impatience and irritability associated with elevations on that scale come from anxiety and poor frustration tolerance rather than hypomanic-drive states.
- o When Antisocial Behavior (RC4) is more elevated than Dysfunctional Negative Emotions (RC7), expect the individual to be more likely to be critical and argumentative and at increased risk for problems with substances. If RC7 is greater than RC4, expect greater anxiety and irritability.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Male

Low 0 Home conflict, father conflict, one interview only, lacks knowledge or information, aggressive or behaviorally uncooperative.

Low 1 Home conflict, nonresponsive or nonverbal.

Low 2/3/5/6/8/9 Home conflict.

Nothing Low Lacks skills with the opposite sex, home conflict, mother conflict, sibling conflict, nonresponsive or nonverbal, tense, indecisive, unhappy, worries a great deal, insomnia, confused, poor rapport.

- Note: Scale 4 coded high was infrequently associated with lack of skills with the opposite sex.

Female

Low 0 Insomnia, rebellious toward home, lacks academic drive, socially extroverted.

Low 1/2 Insomnia, rebellious toward home, socially extroverted.

Low 3 Insomnia, rebellious toward home, cried in the interview.

Low 5 Insomnia, anxieties, headaches, exhaustion, nervous, rebellious toward home, indecisive, lacks self-confidence, socially insecure, lacks skills with the opposite sex.

Low 6 Insomnia, rebellious toward home, vague goals.

Low 8/9 Insomnia, rebellious toward home.

Nothing Low Insomnia, headaches, rebellious toward home, sibling conflict, tense on examinations.

(Drake & Oetting, 1959)

TREATMENT

Look for childhood histories of caregiver inconsistency, with overindulgence and emotional abandonment. These individuals' adaptive response is to both seek reassurance and, at the same time, anticipate its withdrawal.

Consequently, they have difficulty delaying immediate gratification because they distrust the predictability of their reward system. Early childhood histories of unpredictable emotional support may have taught them to obtain what they need without regard for consequences. Therapy should focus on helping them identify stressful situations and rehearse coping strategies that are not self-defeating. Insight-oriented therapy and restimulating past emotional abandonments may help teach them how to recognize and label experiences of anxiety and develop self-soothing coping strategies.

o **Treatment:** Rule out Major Depression; Anxiety Disorders. Motivation for therapy and behavior change may be initially strong but dissipate rapidly in treatment. Goals tend to devolve into short-term anxiety and tension

reduction. May seek to manipulate therapists, family, or both around treatment. Group therapy, referral for substance abuse treatment, or both are usually more effective than individual psychotherapy.

- Frequent diagnoses: antisocial personality, anxiety disorder, alcohol/drug abuse (check the MAC-R, AAS/Alcohol Acknowledgment, APS/Alcohol Potential scales), miscellaneous conditions with impulsive-compulsive styles (e.g., eating disorder programs for persons with bulimia). (Groth-Marnat, 2009)

Treatment Implications

During the early stages of treatment, clients typically show remorse and express the need to change. This might seem sincere but as their guilt diminishes, they will again act out. Thus, therapists should be suspicious of early “easy” gains. Frequently, the person will respond to limit-setting with anxiety and resentment, often either testing the limits or completely ignoring them. The style of acting out followed by guilt is a chronic pattern, and therapeutic attempts to decrease anxiety may actually result in an increase in acting out because the control created by guilt and remorse might be diminished. These individuals may respond well to reassurance and support. However, long-term, fundamental change will be difficult to achieve.

Therapy and Therapeutic Pitfalls

The 4-7 code types have low frustration tolerance. They tend to seek therapy in a crisis, whether due to guilt or the negative consequences of acting out. When the crisis is over, they tend to terminate therapy. The first stage of therapist therapy involves trust building by validating anxiety and reassuring them of support. After establishing trust, teach them to understand how anxiety and tension precipitates impulsive behavior and how they can practice better self-control to control it. Identify precipitating circumstances for acting out, and rehearse new, more controlled self-soothing behaviors. Elicit specific memories of unpredictable, emotional abandonment or parental rejection to foster self-knowledge and self-empathy and to bring awareness about how certain events restimulate their fear of abandonment. Use gestalt techniques to help engage and control anxiety. Teach self-soothing behavior such as thought stopping and relaxation training. Deep breathing (Hazlett-Stevens & Craske, 2009) and progressive muscle relaxation (PMR; Chen et al., 2009) can help with stress management. Understanding how they replicate their relationship with their parents by their approach-avoidance conflicts and learning alternative strategies are among the goals of therapy. As 4-7 behaviors are cyclical, acting out tends to be predictable, so teach them how to anticipate it and to rehearse alternatives. The traditional 50-minute therapy paradigm may be less useful than a coaching model, with the therapist available to coach the client as needed, especially as tension builds and the

risk of an impulsive reaction increases. Substance abuse and other addictive behaviors tend to be minimized but are common. Beware of suicide risk if acting out has led to devastating consequences.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Treatment and Self-Help Suggestions

1. As tension and anxiety build, rehearse with your therapist what kind of impulsive behaviors you use as a way of reducing these feelings. See how these impulsive behaviors have negative consequences that can cause you problems. Explore how you can avoid being impulsive by visualizing stressful situations and rehearsing alternative coping strategies so that you don't continue to act in a cyclical manner from impulsive behavior to guilt, anxiety, and self-criticism. Work with your therapist to identify a specific problem situation, and take an objective look at the consequences. Find alternatives, develop a plan, be specific, and put it in writing. Once you have had a chance to test it out, evaluate the outcome to see if the plan needs revising.
2. A simple and effective tool to help manage intrusive anxious and stressful thoughts is called thought stopping. Whenever you become aware of an unwanted thought, forcefully say to yourself, "Stop." Some people find it helpful to picture a large red stop sign at the same time. Anxious thoughts tend to repeat themselves, so this is a way to disrupt and recognize unhealthy thought patterns. Repeat the technique until the thought leaves your attention. You can then replace it with a more positive and constructive thought (e.g., "I have felt this way before, and I know I can handle this").
3. Learning relaxation techniques such as deep breathing can also help to stop anxious and compulsive thoughts. Controlled breathing helps because when people are tense their breathing is shallow, which sets up a pattern of imbalance of oxygen and carbon dioxide that then increases anxiety. Practice once or twice a day at least 4 minutes at a time, as this is how long it takes to restore balance. Place one hand on your upper chest and one hand on your stomach so that the hand on your stomach moves as you breathe in to a slow count of 4 and breathe out to a slow count of 4.¹
4. Progressive Muscle Relaxation (PMR) is also helpful in combating anxiety. In PMR, major muscle groups are first tensed and then relaxed proceeding from the feet to the head or vice versa. Each muscle group is tensed for 5 seconds and relaxed for 10 to 15 seconds. The more you practice, the more skilled you will become at controlling your anxiety.²

5. Resilience building: Discover with your therapist whether you experienced unpredictable anger or emotional rejection as a child. See if you can remember what it felt like to always be on edge and fearful that something bad was about to happen. It is understandable that this has become a dominant “life story” for you, but discuss with your therapist any alternate outcomes that occurred. Were there times when you felt safe and cared for? Have there been any “surrogate parents” you have found along the way? Are there times when your fearfulness goes away?³
6. Whenever you’re stressed, avoid the temptation to lie or manipulate, and practice confronting the situation directly. Assertiveness training can help you address interpersonal problems in way that is open, honest, and direct. Identify a situation that is stressful, how you feel about it, and what you would like to happen. For example, “When you criticize me, I feel hurt and angry, and I would like you to be more supportive.” Practice in the safety of your therapy session. A good resource for assertiveness skills is *When I Say No, I Feel Guilty* (Smith, 1975).
7. Once you learn to manage your anxiety and avoid impulsive behavior, you can learn to be more balanced rather than going from one extreme to the other.

¹ The controlled breathing technique is detailed in *Mind Over Mood* (Greenberger & Padesky, 1995, p. 185). Deep breathing is an effective method used to counteract chronic anxiety hyperventilation associated with panic disorder and as a general relaxation strategy (Hazlett-Stevens & Craske, 2009).

² Chen et al. (2009) found that the degree of anxiety improvement in a progressive muscle relaxation training group was significantly higher than their control group and that it is a useful intervention across a spectrum of psychiatric disorders.

³ Narrative therapy can help clients find alternatives and assess their problems in a different light. *Narrative Means to Therapeutic Ends* (White & Epston, 1990) outlines the theory and practice of narrative therapy. In the case of clients who have witnessed violent events, Levy and Wall (2000) find that the narrative approach helps construct more effective views of the events, a greater sense of efficacy, and increased resilience. (Levak, Siegel, Nichols, & Stolberg, 2011)

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you go through periods when you become extremely anxious and tense. As your anxiety and tension builds, you have a tendency to act impulsively to relieve the anxiety. Sometimes this tension reduction can involve drugs or alcohol, gambling, sex or some other pleasurable activity that is ultimately self-destructive.

Whenever you act impulsively, especially if you get caught, you experience anxiety, guilt, and remorse, which may change your behavior for a while. However, as stresses build, you may experience an internal struggle, wanting to act on your impulses, but also aware that to do so can cause you guilt and the loss of others' love and approval.

This internal struggle can leave you feeling exhausted and even depressed. You may reach out to others and ask for reassurance and advice, but when you get it, it is hard for you to trust it. You may have grown up with inconsistent caregivers. Perhaps one of your parents would be impulsively explosive or withdraw from you in ways that felt like abandonment. Sometimes they may have been very loving, even indulgent, but you learned from an early age that you could not trust their consistency. It is no wonder that you learned to "grab what you could," when you could, rather than learning to postpone gratification in order to work toward long-term goals. Work with your therapist to identify experiences you had as a child when you felt unpredictably emotionally abandoned. Identify the feelings associated with those events so you can learn to recognize when you are becoming fearful or tense, and learn to self-soothe in healthy ways, rather than impulsively acting out. Identify people you can trust and be meticulously honest with them, rather than selectively reporting. Rehearse stressful situations and coping strategies so you do not act impulsively and later regret it. Eliminate self-destructive self-soothing behaviors.

Feedback Statements—Elevated Profiles (T-Score > 65)

Strengths

Your profile suggests you have a number of possible strengths. You enjoy excitement, are adventurous, and are able to take risks but, at the same time, you are responsible and prone to worry. Unfortunately, these two sets of traits coexist in you in a way that causes you difficulty.

Guilt, Anxiety, Impulsivity

It appears that you spend much time with mixed feelings, alternating between guilt and anxiety on one hand and, then as stress and tension build, impulsiveness and risk-taking on the other hand as a way of relieving the tension.

Self-Critical or Insecure

After you've acted on your impulses and done something risky or self-defeating, you probably experience self-doubt or even self-hatred. The consequences of your rash behavior may frighten you, and then you're liable to become self-

critical and insecure. You want reassurance that people won't abandon you, and during these times you might promise people that you will never act impulsively again. As things settle down and you feel more secure, you might find yourself starting to feel restless, bored, and in need of excitement, risk, and even danger. It's possible that these two sides of you—the spontaneous risk taker and your worried and fretful side—would work better if not at war with each other. Finding the right balance is going to be an important part of your therapy.

Manipulative or Difficulty Making Decisions

You also may find yourself becoming manipulative when you are anxious, doing whatever it takes to get your needs met. During these times, you may not tell the truth, or you may selectively report or somehow bend the truth to get your way. Because there are these two competing sides of you, you may find making decisions extremely difficult. You see every side of every issue, and you feel apprehensive about making the wrong decision. You may ask many people their opinion but find it hard to trust any of them. You may also find it hard to express anger toward people, afraid that if you do so they will abandon you emotionally. When anger does come, it probably comes out as a sudden eruption of feelings that you don't control well.

Lifestyle and Background Feedback

Typically, people with your profile grew up in environments where parents were inconsistent. Maybe one of them was indulgent and permissive but didn't appear to really care about your needs. Perhaps the other parent was strict and demanding. It's also possible that the same parent would alternate between periods of being demanding, critical, and maybe even explosive and then at other times neglectful. You learned to be on guard for something bad to happen, unable to trust your relationships because they were not stable and reliable. When you became stressed or anxious, you had trouble trusting that a parent would be there to recognize and try to reassure and ease your discomfort. You would act impulsively to relieve stress, trying to get your needs met immediately. Your impulsivity has probably gotten you into trouble, especially if you use drugs or alcohol as a way of relieving stress. You worry and wait for someone you love to either get angry at you or abandon you. Yet when you feel love from the person you care about, you might feel hemmed in, controlled, or bored. You might be tempted to distract yourself with other relationships or the things that excite you. However, if you feel vulnerable to losing the person you care about, you panic and cling to them until you feel safe.

Normal-Range Feedback (T-Score 50 to 65)

Your profile is within the normal range. However, it shows that when you become anxious you have a tendency act impulsively, leading to consequences which you regret later. When this happens, you may worry and feel guilty

about what you have done, which leads you to become more tense and increases the likelihood of another impulsive act. You may use chemical agents, overeat, overspend, or have some other habits that serve as a way to immediately reduce tension. Generally, you find conflict difficult, and you may find yourself being manipulative to find ways to avoid confrontations. You also avoid situations that might make you angry, but when you finally do feel angry it may come out impulsively, due to the buildup of tension. After your angry outburst you may feel very guilty and remorseful.

(Levak, Siegel, Nichols, & Stolberg, 2011)

472 Code

Marks et al. (1974) found the 2-7-4/2-4-7/4.7-2 pattern in a university hospital and outpatient clinic. People with this pattern tended to be depressed and to have many worries. They were likely to be described as passive-aggressive, generally tearful, full of fear, nervous, and irritable. The Marks, Seeman, and Haller book should be consulted for further information concerning this profile.

478 Code

This profile predicts impulsive and sometimes compulsive, alienated and self-defeating acting-out behavior in order to immediately reduce tension. These individuals manifest severe anxiety, with resulting problems in concentration, memory, and general efficiency. Psychotic symptoms with disorientation and poor reality testing can occur in some cases. The addition of Scale 8 to the 47 codetype predicts a damaged identity with a history of self-esteem-damaging experiences. The intense ambivalence of the 47 is aggravated by the Scale 8 fear of emotional closeness and intimacy. Individuals with this codetype may confuse sexuality with aggression and often exhibit sexual difficulties associated with their fears of intimacy. Addictive behaviors, odd preoccupations and ruminations, unpredictable acting out, and fears of emotional closeness are typical. Depression and emotional estrangement are also present, even if Scale 2 is not elevated above *T*-65. Look for childhood experiences of ambivalent, unpredictable, and cruel caretakers. The adaptive response in such an environment was an attempt to predict and anticipate the onset of identity damaging hostility from an unpredictably cruel caretaker. If the cruelty were inescapable, a retreat into fantasy and resulting cognitive overload would be understandable responses. Maintaining a protective emotional distance would also be understandable.

o 4-7-8/4-8-7/7-4-8/7-8-4/8-4-7/8-7-4

o Graham et al. (1999) described their outpatients with this profile as manifesting symptoms of anxiety, including problems in concentration; agitation; phobias and obsessive-compulsive symptoms; and symptoms of psychosis, including disorientation, derailment, poor reality testing, hallucinations, and delusions. They also described patients as introverted, insecure, emotionally shallow, self-degrading and self-punishing, interpersonally sensitive and suspicious, and as having suicidal ideation.

Male

Low 0 Home conflict, father conflict, one interview only, nonresponsive or nonverbal, tense, indecisive, lacks knowledge or information, vague goals, confused, aggressive or belligerent.

- Note: Scale coded low was infrequently associated with being nonresponsive or nonverbal, indecisiveness.

Low 1/2/3/5/6 Home conflict, nonresponsive or nonverbal, tense, indecisive, lacks knowledge or information, vague goals, confused.

Low 9 Introverted or self-conscious or socially insecure, home conflict, nonresponsive or nonverbal, tense, indecisive, lacks knowledge or information, vague goals, confused.

Nothing Low Lacks skills with the opposite sex, home conflict, mother conflict, sibling conflict, nonresponsive or nonverbal, tense, indecisive, unhappy, worries a great deal, insomnia, lacks knowledge or information, vague goals, confused, poor rapport.

- Note: Scale 4 coded high was infrequently associated with lack of skills with the opposite sex.

Female

Low 0 Insomnia, depressed, nervous, rebellious toward home, overprotective mother, socially extroverted, lacks academic drive, verbal, lacks selfconfidence.

- Note: Scale coded low was infrequently associated with depression and lack of self-confidence.

Low 1 Insomnia, depressed, nervous, rebellious toward home, overprotective mother, socially extroverted, lacks self-confidence.

Low 2 Insomnia, depressed (48), nervous, rebellious toward home, overprotective mother, socially extroverted, lacks self-confidence.

- Note: Scale 2 coded low was infrequently associated with lack of self-confidence.

Low 3 Insomnia, depressed, nervous, rebellious toward home, overprotective mother, lacks self-confidence, cried in the interview.

Low 5 Insomnia, depressed, nervous, anxieties, headaches, exhaustion, rebellious toward home, overprotective mother, lacks skills with the opposite sex, socially insecure, distractible in study, lacks self-confidence, indecisive.

- Note: Scale 4 coded high was infrequently associated with social insecurity.

Low 6 Insomnia, depressed, nervous, rebellious toward home, overprotective mother, vague goals, lacks self-confidence.

Low 9 Insomnia, depressed, nervous, rebellious toward home, overprotective mother, lacks self-confidence.

Nothing Low Insomnia, depressed, nervous, exhaustion, headaches, rebellious toward home, overprotective mother, mother conflict, father conflict, sibling conflict, lacks skills with the opposite sex, tense on examinations, lacks self-confidence, 8+ conferences.

(Drake & Oetting, 1959)

TREATMENT

These individuals tend to be manipulative because they distrust others, and may selectively report, if not lie. Because the boundary between their inner experience and reality can become blurred under stress, obtaining an accurate picture of presenting problems and stressors can be difficult and confusing. Scale 8 elevations suggest a damaged identity, indicating supportive nurturing therapies. Therapeutic structure is important since these individuals can be easily disorganized when conversations touch upon anxiety-laden topics. Relaxation training, thought stopping, and cognitive restructuring can be useful to help them manage anxiety. Because the 478 individual has experienced unpredictable, cold, rejecting hostility, their compulsive preoccupation with avoiding it makes adaptive sense. However, the cognitive disorganization associated with Scale 8 would predict poor reality testing. Helping them learn to recognize when they experience cognitive disorganization through CBT, and teaching thought-stopping techniques and relaxation can be helpful.

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you are currently experiencing a great deal of anxiety. People with your profile often grow up in environments where parents were unpredictable, and sometimes cruel and coldly rejecting. From an early age you may have learned to protect yourself by withdrawing and not allowing yourself to feel vulnerable or depend on anyone emotionally. Your profile suggests that you experience periods of panic and confusion, especially if you feel somebody you depend on is angry with you or is rejecting you. When stresses accumulate, you may act out impulsively, sometimes in ways that later appear odd or self-defeating. At times it may be hard for you to think clearly or make decisions. It is as if you're going through life constantly on edge, anticipating that something bad is about to happen, and that you will be treated cruelly, rejected, or abandoned. Work with your therapist to rehearse stressful situations and coping strategies so that you do not act impulsively in difficult situations. Learn to recognize when you feel panicked and when your thinking becomes disorganized, so that you avoid impulsive decisions during these times. Learn ways to soothe yourself, to relax and control your panic, so that you can think more clearly. As

you become more trusting of your therapist, talk about any events in your childhood where you felt overwhelmed by a parent's cruelty or neglect. Through therapy, learn how you can recognize when people are trustworthy so that you can begin to open up and let down your guard enough to allow yourself to depend on others.

479 Code

Male

Low 0 Home conflict, father conflict, one interview only, lacks knowledge or information, aggressive or belligerent, defensive. This pattern was infrequently associated with shyness in the interview, being nonresponsive or nonverbal, being nonverbal or a nonrelator, indecisiveness.

Low 1 Home conflict, defensive, nonresponsive or nonverbal.

- Note: Scale 9 coded high was infrequently associated with being nonresponsive or nonverbal.

Low 2 Home conflict, defensive, aggressive or belligerent.

Low 3/5 Home conflict, defensive.

Low 6 Introverted or self-conscious or socially insecure, home conflict, defensive, rationalizes a great deal.

Low 8 Home conflict, defensive.

Nothing Low Lacks skills with the opposite sex, home conflict, mother conflict, sibling conflict, nonresponsive or nonverbal, tense, indecisive, imhappy, worries a great deal, insomnia, confused, poor rapport, defensive.

- Note: Scale 9 coded high was infrequently associated with indecisiveness, being nonresponsive or nonverbal, worrying a great deal, lack of skills with the opposite sex.

Female

Low 0 Insomnia, nervous, exhaustion, rebellious toward home, sibling conflict, home conflict, confused, distractible in study, vague goals, marriage oriented, lacks academic drive, verbal, socially extroverted.

- Note: Scale 0 coded low was infrequently associated with exhaustion, sibling conflict, home conflict, confusion.

Low 1 Insomnia, nervous, rebellious toward home, sibling conflict, home conflict, confused, distractible in study, vague goals, verbal, socially extroverted.

Low 2 Insomnia, nervous, rebellious toward home, sibling conflict, home conflict, confused, distractible in study, vague goals, verbal, socially extroverted.

- Note: Scale 2 coded low was infrequently associated with home conflict and confusion.

Low 3 Insomnia, nervous, rebellious toward home, sibling conflict, home conflict, confused, distractible in study, vague goals, verbal, cried in the interview, socially extroverted.

Low 5 Insomnia, nervous, anxieties, exhaustion, headaches, rebellious toward home, sibling conflict, home conflict, confused, indecisive, lacks selfconfidence, distractible in study, vague goals, verbal, socially extroverted (49), lacks skills with the opposite sex, socially insecure (7-5).

Low 6/8 Insomnia, nervous, rebellious toward home, sibling conflict, home conflict, confused, distractible in study, vague goals, verbal, socially extroverted.

Nothing Low Insomnia, nervous, headaches, rebellious toward home, sibling conflict, home conflict, confused, distractible in study, vague goals, tense on examinations, verbal, socially extroverted.

(Drake & Oetting, 1959)

48/84 Codes

Code-Type 4-8/8-4

Descriptors

Complaints

Moodiness, depression, anxiety, anhedonia, sleep disturbance, hopelessness, restlessness, irritability, family alienation, early childhood abuse or neglect, fears of trusting, paranoia, alienation, possible substance abuse, possible suicidal threats or behaviors, self-defeating and self-destructive acts

Thoughts

Distrustful, feelings of inferiority, ideas of reference, paranoid thoughts, poor reality testing, sexual/aggressive fantasies, argumentative, resentful of demands, morbid ruminations, projecting and rationalizing

Emotions

Alienated, anhedonic, emotional numbing, fears of emotional involvement, unable to trust and let go emotionally, inappropriate affect, lacking empathy, paranoid

Traits and Behaviors

Unpredictable, nonconforming, alienated, resentful, impulsive, can act out antisocially, mature, self-defeating, borderline traits, sexuality/aggression confusion, demanding of affection but distrustful, lacking in empathy, questions others' motives, poor relationship adjustment, self-destructive or self-defeating acts

(Levak, Siegel, Nichols, & Stolberg, 2011)

Therapist's Notes

In the normal range, this profile is associated with nonconformity, eccentricity, difficulties with trust and intimacy, and deficits of empathy. Acting out and resistance to traditional lifestyles are typical. At higher elevations, deep mistrust is the central characteristic. Individuals with this profile fear emotional involvement and maintain emotional distance from others. In spite of their distrust, they have an exaggerated need for affection, attention, and

validation. They can be self-protectively irritable, resentful, and argumentative. This profile is often associated with childhoods of sexual or emotional abuse, neglect, and cruelty. Clients with this profile report depression, anxiety, somatic symptoms, mistrust, and anhedonia. They experience the world as a frightening place where others cannot be trusted or relied upon, and they feel unable to effectively comprehend others' emotional states. Ideas of reference and transient paranoid states are common. They tend to confuse sexuality and aggression and often become involved in sadomasochistic and self-defeating relationships. Feelings of hopelessness can lead to suicidal ideation and selfdestructive acts, reflecting their desperation and alienation. These individuals are suspicious, argumentative, and very sensitive to any demands placed on them. Their profile can be characterized as reflecting a damaged capacity to form interpersonal bonds due to early hostility, abandonment, and cruel neglect. They exhibit distorted thinking and are often described by acquaintances as somewhat odd and eccentric. They tend to react in emotionally unpredictable ways that can result in self-defeating, destructive bizarre and senseless acts. Crimes committed by 4-8 individuals tend to be random, senseless, poorly planned, and poorly executed. As one would expect with a combination of Scales 4 and 8, when angry impulses erupt they are shaped through the lens of alienation, distorted thinking, and an accumulation of internalized aggression, so their acting out can be savage and senseless and can sometimes contain a sexual overtone. Interestingly, many 4-8 individuals do not exhibit gross or florid thought disorder symptoms.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Lifestyle and Family Background

The 4-8 profiles reflect an adaptive response to parental cruelty and overwhelming rejection. Numbing out emotional responsiveness and escaping into retaliatory aggressive fantasy would make sense in an environment of overpowering hostility and neglect. The lifestyle and family background of the 4-8 code type is similar to that of an unwanted and rejected child. Studies conducted in Czechoslovakia just after the collapse of the Soviet Union examined the histories of children born to mothers who had attempted to abort them. It was found that these children began developing behavior problems by the age of 3 or 4, school problems before the age of 10, and alienation and authority problems in early adulthood (David, Dytrych, Matejcek, & Schuller, 2003). Characteristics described by the authors show remarkable similarity to 4-8 attributes. A large majority of 4-8 code types have reported histories of parental domination and rejection. We hypothesize that their adaptive response was to "reject first" and not to allow emotional closeness. They tend to replicate their childhoods by becoming involved with controlling and rejecting individuals. They are often single or in conflicted, abusive relationships. They have difficulties being effective parents because of their lack of empathy, yet being a parent is very important to them.

(Levak, Siegel, Nichols, & Stolberg, 2011)

This codetype is characterized by distrust, alienation, and a sense of emotional disconnection from others. People with this codetype have difficulties forming emotional attachments due to their profound mistrust and their difficulties with empathy. Often Scale *F* is elevated, reflecting internal turmoil and an external life that is often marginal if not largely dysfunctional. *VRIN* may also be elevated, although the elevation does not necessarily indicate invalidity as much as it reflects mental confusion. In the majority of cases, the behavior of 48/84 is consistent with the borderline personality pattern, with more or less frequent episodes in which they behave in self-defeating, if not self-destructive ways. Some may experience occasional and brief episodic breaks with reality which strikes others as unusually odd, even bizarre. Thereafter, they usually quickly reconstitute, perhaps as the stresses that led to them lift or are resolved. In some cases more persistent signs of psychosis are seen, with hallucinations, delusional thinking, aggression, and an increased likelihood of prior psychiatric hospitalization. They are often highly impulsive and unpredictable, with chaotic lives. Even when Scale 2 is not elevated, they experience anhedonia, sleep difficulties, feelings of hopelessness and defeat, and suicidal ideation. They also can be highly irritable or unable to tolerate frustration and, when frustrated, quickly become angry, if not openly hostile. Others describe them as immature, and their actions often appear odd, peculiar, and self-defeating. Chronic poor judgment often leads to a marginal social adjustment. They are described as emotionally distant, although some espouse esoteric belief systems that can be appealing to other alienated people for brief periods of time. Others may describe them as peculiar in thought and action, unpredictable and moody. Interpersonal relationships are difficult because their angry, anhedonic moods, which do not appear tied to specific external events, can be difficult to live with. Educational and occupational histories are marked by underachievement and marginal adjustments, with serious lapses in responsibility. Many 48 individuals report having been sexually abused. Some 48/84 individuals become social isolates or nomads, whereas others become involved in antisocial or criminal activity. When these individuals commit crimes, they often seem senseless, brutal, and poorly planned and may include sexual or homicidal attacks. Individuals with this codetype often become involved with others who are equally marginally adjusted. They were often born to parents who were rejecting of them and they, in turn, often have children early and develop ambivalent attachments to them.

The 48/84 has low self-esteem and so is vulnerable to being abused. They fear emotional closeness, although they can be very active sexually. Bright, educated individuals with this codetype may not exhibit marginal social adjustment, but rather a chaotic interpersonal life, severely damaged self-esteem, periods of diffuse anxiety, a tendency to keep others at an emotional distance, and occasional breakdowns in reality testing, such as misinterpreting others'

motives and paranoid thoughts. They also may experience difficulties with trust and intimacy, which may be evidenced in marital difficulties, lack of empathy, and sexual acting out.

As 48 individuals in general are anhedonic, alienated from others and can be impulsive and angry, suicide threats should be taken seriously. Chemical addiction is associated with this codetype. In adolescents, this codetype is fairly common and may reflect a transient adjustment disorder subsequent to an identity-damaging experience. In other adolescents, however, it may reflect a pre-psychotic process. These adolescents, like their adult counterparts, are angry, distrustful, and unhappy, reveal disturbances in thinking, have interpersonal difficulties, and are impulsive and nonconforming. They keep others at a distance, and some go out of their way to appear frightening or even disgusting to others. Typically, these adolescents are academic underachievers and may be delinquent, although in some their delinquency is confined to substance abuse. Anorexia, hyperactivity, and histories of enuresis and encopresis may be present.

- o Doesn't seem to fit into environment; odd, peculiar, queer; non---conforming and resentful of authority; may espouse radical religious or political views; erratic, unpredictable; problems with impulse control; angry, irritable, resentful; acts---out in asocial ways; delinquency, criminal acts, sexual deviation may be present; excessive drinking and drug abuse (especially hallucinogens); underachievement, marginal adjustment

- o Deep feelings of insecurity; exaggerated needs for attention and affection; poor self--- concept; sets self up for rejection and failure; periods of suicidal obsessions; distrustful; avoids close relationships; impaired empathy; lacks basic social skills; withdrawn, isolated; sees world as threatening and rejecting; withdraws into fantasy or strikes out in anger as defense against being hurt; accepts little responsibility for own behavior; rationalizes; blames others for difficulties; harbors strong concerns about masculinity or femininity; obsessed with sexual thoughts; afraid of being unable to perform sexually; may indulge in antisocial sexual acts in attempt to demonstrate sexual adequacy; most common diagnoses are schizophrenia (paranoid type), asocial personality, schizoid personality, and paranoid personality

Individuals with this high point pair are experiencing considerable distress in addition to irritability, hostility, suspiciousness, and even possibly ideas of reference. Projection and acting out in asocial ways are primary defenses. Whenever they commit crimes, they tend to be viscous, senseless, poorly planned, and poorly executed. The personality type is schizoid and these clients appear socially isolated and avoid close relationships because of fear of emotional involvement. Social intelligence is likely to be limited and serious difficulties can be expected in the areas of empathy and communication abilities. Individuals with this high point pair are moody, emotionally inappropriate, and cannot express emotions in a modulated, adaptive way. In their behavior, these clients are

unpredictable, changeable, and nonconforming. Their educational and occupational histories are noted by underachievement, marginal adjustment, and uneven performance. Serious sexual identity concerns are present and excessive alcohol consumption and/or drug abuse is likely. Judgment tends to be poor and insight is extremely limited. Suicide attempts are relatively common. Others perceive individuals with this high point pair as rather odd, peculiar, different, and not seeming to fit into the environment. The diagnostic possibilities include a borderline disorder, schizoid personality, or schizophrenia. The latter is most likely when Scales 4 and 8 are elevated above a T score of 75. Psychotherapy is likely to be unproductive at worst and difficult at best.

Symptoms and Behaviors

Persons with the 48/84 code are strange, eccentric, emotionally distant, and have severe problems with adjustment. Their behavior is unpredictable and erratic, and may involve strange sexual obsessions and responses. Usually, there will be antisocial behavior resulting in legal complications (check the ASP/Antisocial Practices scale). These individuals also lack empathy, and are nonconforming and impulsive. Sometimes, they will be members of strange religious cults or unusual political organizations.

In their early family histories, they learned that relationships were dangerous because of constant confrontation with intense family conflicts. They were rejected and, as a result, felt alienated and hostile, sometimes attempting to compensate with counter-rejection and other forms of retaliation. Their academic and later work performance has usually been erratic and characterized by underachievement. In interpersonal relationships, their judgment is generally poor and their style of communication is likely to be inadequate. Often, others feel as if they are missing important elements or significant connotations of what the 48/84 individual is saying, but they cannot figure out exactly what or why. If *F* is elevated with a low Scale 2, these individuals are typically aggressive, cold, and punitive, and have a knack for inspiring guilt and anxiety in others. Often, they take on roles in which such behavior is socially sanctioned, for example, a rigid law enforcement officer, overzealous member of the clergy, or a strict school disciplinarian. Their behavior may range all the way from merely stern, punitive, and disapproving, to actual clinical sadism. Underneath these overt behaviors, they usually have a deep sense of alienation, vulnerability, and loneliness, which may give rise to feelings of anxiety and discomfort. Criminal behavior occurs frequently in males with a 48/84 code type, especially when Scale 9 is also elevated. The crimes are likely to be bizarre, and often extremely violent, involving homicide and/or sexual assault. These behaviors are usually impulsive, poorly planned, without apparent reason, and generally self-defeating, eventually resulting in self-punishment. Females are less likely to act criminally, but their relationships will usually be primarily sexual and they will rarely become emotionally close. Often, they will form relationships with men who are significantly inferior to themselves and who could be described as losers.

The most likely diagnosis is a schizoid or paranoid personality. However, a psychotic reaction, often paranoid schizophrenia, is also common, especially with elevations on Scale 6.

Personality and Interpersonal Characteristics

Although these individuals have deep needs for attention and affection, they frequently set themselves up for rejection and failure. They have deep feelings of insecurity and a poor self-concept.

o Severe alienation with pervasive distrust of others and fear of emotional involvement. Behavior pattern is impulsive, chaotic, and unpredictable. Depressed, anxious, tense, ruminative and worried, with moodiness, anhedonia, anergia/fatigue, sleep disturbance, hopelessness, and guilt, but also agitation/restlessness, irritability, intolerance of frustration, and hostility. Immature and self-defeating, with chronically poor judgment and feelings of inferiority. Thought disorder with hallucinations and ideas of reference is not common but may be covered by withdrawal, mistrust, and acting out. Spends much time in fantasy and daydreaming, the themes of which are often morbid, involving physical and sexual violence. Poorly developed conscience. Interpersonally detached and cold; potentially sadistic. Rebellious toward authority figures; generally resentful and argumentative. Feels misunderstood and rejected. Craves affection but lacks empathy; fearful of rejection and intolerant of vulnerability. Expects mistreatment and questions others' motives. Prefers to reject others before others reject the patient (felt to be inevitable). Defends through acting out, projection, and rationalization. Sexual psychopathology common; tends to conflate sex with aggression. Borderline and/or antisocial trends. Look for a history of abuse (sexual abuse for women), family deprivation and neglect, chronic exposure to conflict, or being the target of bullying; children born out of wedlock and put up for adoption (women), multiple abortions (women); underachievement; employment and relationship instability; delinquency and criminality; sexual promiscuity/prostitution or paraphilias; family and marital conflict; self-mutilation and suicidal threats, gestures, and attempts; and substance abuse.

48/84 individuals do not seem to fit into their environments. They are seen by others as odd, peculiar, and queer. They are nonconforming and resentful of authority, and they often espouse radical religious or political views. Their behavior is erratic and unpredictable, and they have marked problems with impulse control. They tend to be angry, irritable, and resentful, and they act out in asocial or antisocial ways. When crimes are committed by 48/84 persons, they tend to be vicious and assaultive and often appear to be senseless, poorly planned, and poorly executed. Prostitution, promiscuity, and sexual deviation are fairly common among 48/84 individuals. This is the most common code type among male rapists. Excessive drinking and drug abuse (particularly involving hallucinogens) may also occur. Histories of 48/84 individuals usually indicate underachievement, uneven performance, and

marginal adjustment. Persons with the 48/84 code type harbor deep feelings of insecurity, and they have exaggerated needs for attention and affection. They have poor selfconcepts, and it seems as if they set themselves up for rejection and failure. They may have periods during which they become obsessed with suicidal ideation. 48/84 persons are quite distrustful of other people, and they avoid close relationships. When they are involved interpersonally, they have impaired empathy and try to manipulate others into satisfying their needs. They lack basic social skills and tend to be socially withdrawn and isolated. The world is seen as a threatening and rejecting place, and their response is to withdraw or to strike out in anger as a defense against being hurt. They accept little responsibility for their own behavior, and they rationalize excessively, blaming their difficulties on other people. 48/84 persons tend to harbor serious concerns about their masculinity or femininity. They may be obsessed with sexual thoughts, but they are afraid that they cannot perform adequately in sexual situations. They may indulge in antisocial sexual acts in an attempt to demonstrate sexual adequacy.

Psychiatric patients with the 48/84 code type tend to be diagnosed as schizophrenic (paranoid type) or as having an antisocial, schizoid, or paranoid personality disorder. If both scales 4 and 8 are very elevated, and particularly if scale 8 is much higher than scale 4, the likelihood of psychosis and bizarre symptomatology, including unusual thinking and paranoid suspiciousness, increases.

Persons with this profile pattern are frequently described by acquaintances as odd, peculiar, or queer. They are unpredictable, impulsive, and nonconforming and the term schizoid personality is frequently applied to them. Their educational and occupational histories are characterized by underachievement, marginal adjustment, and uneven performance. Nomadism, social isolation, or underworld membership is often present. Delinquency is closely associated with the 48 profile (Hathaway and Monachesi, 1953) and the prognosis for improvement under a rehabilitation program for delinquents is poor (Lauber and Dahlstrom, 1953). Crimes committed by persons with this profile (Pothast, 1956) are often senseless, poorly planned, and poorly executed, and may include some of the most savage and vicious forms of sexual and homicidal assault. The small group of medical patients (mostly women) with this profile pattern in Guthrie's study did not show frankly bizarre behavior. However, the degree of personality involvement in these patients may be inferred from the vague physical complaints that characterized them, the recurring history of changes from doctor to doctor, and the lack of follow-up visits; the impression of the internist supported the picture of deep involvement. Over half of the group were considered early psychotic reactions. In addition to their vague, multiple complaints, they showed considerable anxiety at the time they were seen. Only one patient returned for a second visit in spite of encouragement to do so. The combination of high 482 codes is included in the Marks and Seeman Atlas (see Chapter 3 for the defining characteristics of this

pattern).

(Dahlstrom, Welsh, & Dahlstrom, 1979)

48 See also the 84 combination, p. 209.

1. People with this pattern may be unpredictable, impulsive, and odd in appearance and behavior (Dahlstrom et al., 1972; Hovey & Lewis, 1967).
2. People with this pattern tend to distrust others and have problems with close relationships (Caldwell, 1972).
3. These people tend to see the world as threatening, and they respond by either withdrawing or lashing out in anger. They may have serious concerns about their masculinity or femininity (Graham, 1977).
4. They tend to get into trouble because they have poor judgment as to when and how to fight out, rather than because they crave the excitement of trouble as people with the 4-9 pattern do.
5. One study (Lewandowski & Graham, 1972) has found that hospitalized psychiatric patients with this pattern have more unusual thoughts than other psychiatric patients and also are younger than the other patients.
6. This pattern is found frequently in people with suicidal ideation (Caldwell, 1972).
7. The person with the high 4 and 8 scales and a low 9 scale may be the black sheep of the family and constantly in trouble (Caldwell, 1972).
8. Gynther et al. (1973) found that psychiatric inpatients with the 44/8-4 pattern had a history of antisocial behavior such as promiscuity or deserting their families.
9. VA hospital males were likely to be argumentative, unpredictable, odd, delinquent, and asocial (Hovey & Lewis, 1967).
10. Adolescents in treatment with the 41/8-4 pattern (Marks et al., 1974) were immature and extremely narcissistic. Only 16010 showed any improvement in therapy. These adolescents were argumentative,

resentful, and acting out. Those with the 44 pattern were more deviant and difficult in therapy than those with the 8-4 pattern. The Marks, Seeman, and Haller book should be consulted for further information concerning this pattern.

11. Crimes committed by persons with this profile often are senseless, poorly planned, and poorly executed. They may include some of the more savage and vicious forms of sexual and homicidal assault (Pothast, 1956).
12. Anderson and Holcomb (1983) found this pattern as one of five in a group of murderers. Men with this pattern were most clearly identified by others as having severe mental problems. They tended to kill as the result of insults or slights. They were least likely to be drunk when they killed. Their profile pattern resembles Megargee and Bohn's (1979) Howe pattern.
13. In a recent study (Craig, 1984a), 9% of the heroin addicts had the 44/8-4 pattern, 21010 had the 4-9/94 code, and 14% the 4-2/2-4 code.
14. In another study of drug abusers (Patalano, 1980) this was the most frequent two point code for Black abusers. The 4-9/9-4 code was the most frequent code for whites.
15. Caldwell (1972) found in one MMP1 study of prostitutes and call girls that all of them had the 4-8 combination.
16. College men with this pattern tended to be indecisive, unhappy, worrying, and confused. They had conflicts with their fathers and were aggressive and belligerent. Females also had conflicts at home, were depressed, and had headaches. They also lacked skills with the opposite sex (Drake & Oetting, 1959).

Description:

Narcissistic, unpredictable, schizoid, antisocial, with underlying dependency and loss of control, perceive others as hostile and dangerous, may have periods of suicidal ideation or aggression, avoid constancy and responsibility

Possible Diagnoses:

Exhibitionism, Pedophilia, Psychopathy, Schizoid, Antisocial, Borderline, Pyromania, Rape, Paranoid schizophrenia, Sexual sadism, Aggressive conduct dis.

Modifying Scales

- When Defensiveness (K) is elevated, expect less obvious acting out, especially if Ego Strength (Es) is also elevated. These elevations would predict better self-control and superficial poise but also the more effective manipulation of others. Acting out might be interpersonal rather than antisocial, especially if Antisocial Practices (ASP) is not elevated above a T-score of 70.
- Typically, Scale 2 is also elevated, reflecting the anhedonia associated with this code type; these clients may also exhibit some of the physiological symptoms associated with depression. In some cases, antidepressant medication can alleviate their symptoms.
- When Scale 3 is elevated, it suggests some attempts at connecting with others, although the drive for self-protective distance is stronger. Typically, these individuals will play the correct social role, although they exhibit odd behaviors. The 3-4-8 code types' attempts at interaction and closeness will tend to be clumsy because of their damaged self-image and poor reality testing. Peculiar ideologies and inappropriate seductiveness indicate hysterical defenses against alienation and distrust.
- A number of the content scales may be elevated, reflecting diffuse anxiety, somatic symptoms, family alienation, cynicism, and antisocial practices.
- Elevated Antisocial Behavior (ASP) increases the possibility of violent acting-out behavior, particularly if direct threats are made. This is particularly true if ASP, Anger (ANG), and Cynicism (CYN) are all elevated.
- When Obsessions (OBS) is elevated, examine the focus of obsessive thoughts and be aware of the possibility of violent obsessions.
- When Bizarre Mentation (BIZ) or Aberrant Experiences (RC8) or Psychoticism (PSYC) is elevated, rule out the possibility of a schizophrenic disorder.
- Negative Treatment Indicators (TRT) elevated would confirm a lack of trust in the therapeutic process.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Male

Low 0 Father conflict, lacks knowledge or information, aggressive or belligerent.

Low 9 Introverted or self-conscious or socially insecure.

Nothing Low Indecisive, unhappy, worries a great deal, insomnia, confused.

Female

Low 0 Depressed, insomnia, overprotective mother, socially extroverted, lacks academic drive, verbal.

- Note : Scale coded low was infrequently associated with depression.

Low 1 Depressed, insomnia, overprotective mother, socially extroverted.

Low 2 Depressed (48), insomnia, overprotective mother, socially extroverted.

Low 3 Depressed, insomnia, overprotective mother.

Low 5 Depressed, insomnia, anxieties, overprotective mother, rebellious toward home, lacks skills with the opposite sex, indecisive, distractible in study.

Low 6 Depressed, insomnia, overprotective mother, vague goals.

Low 7/9 Depressed, insomnia, overprotective mother.

Nothing Low Depressed, insomnia, headaches, overprotective mother, mother conflict, father conflict, sibling conflict, lacks skills with the opposite sex, 8+ conferences

(Drake & Oetting, 1959)

o **Check:** *ANX, DEP, DEP1, DEP2, DEP3, DEP4, RC2, DisOrg, RC8, HEA2, BIZ1, BIZ2, ANG1, ANG2, CYN1, CYN2, ASP1, ASP2, TPA1, TPA2, LSE1, FAM1, FAM2, AGGR, PSYC, DISC, Dr1, Dr2, Dr3, Dr4, Dr5, Hy3, Hy2 (low), Hy5 (low), Pd1, Pd2, Pd3, Pd4, Pd5, Pa1, Pf1, Pf2, Pf3, Pf4, Pa2, Pa3 (low), Sc1, Sc2, Sc3, Sc4, Sc5, Sc6, Ma1, Ma4, Si3, A, R, Re, GF (low), MAC-R, AAS, MDS.*

TREATMENT

These individuals experience disruptive, chaotic, abusive, and identity-damaging childhoods. Look for chronic family conflict, sexual abuse, alcoholism, and cruel neglect in the family of origin. Often they have been labeled as “the bad apple” in the family and are, therefore, singled out for particularly harsh treatment. The profile reflects this damaged sense of identity. As an adaptive response to hostility, the 48/84 individual may have learned to view others as untrustworthy, rejecting, hostile, or dangerous, and therefore established an enduring attitude of mistrust, and protective, hostile, emotional withdrawal from others. Many respond defensively by keeping others at a distance and lashing out at anyone who frustrates or rejects them. A therapeutic alliance is difficult, as they mistrust the therapist and are often evasive in treatment. They put the therapist through “trust tests” and, if the therapist “passes,” a therapeutic alliance can develop. It would be important to discuss the transference on an ongoing basis in order to facilitate the development of trust. They are self-protectively manipulative, which reflects their experience of caretakers as having been unreliable and rejecting. Insight therapies tend to be disorganizing to these individuals. Reparenting, supportive therapies combined with an empathic understanding of early childhood experiences of

abuse or neglect can be helpful. Practical life skill training and developing basic coping strategies to avoid a marginal social adjustment may be most useful. Psychotropic medication may be appropriate, although they may have difficulty trusting the therapist enough to conform to a medication regimen.

o **Treatment:** Rule out Psychosis/Schizotypal Personality Disorder; Borderline Personality Disorder; Paranoid Personality Disorder. Biological therapies only marginally effective but may provide limited symptomatic relief of anxiety and depression. Major difficulties establishing trusting relationship with therapist. Prognosis consistently better for women than for men, and for younger patients than older patients. Structured therapies such as dialectical behavior therapy and cognitive behavioral therapy are often effective.

- Frequent diagnoses: schizoid or paranoid personality, psychotic reaction, paranoid schizophrenia (especially with high 6).

Treatment Implications

Because the client will be aloof and unconventional, it will be difficult to establish a therapeutic relationship. The sessions are likely to be chaotic with difficulty focusing on relevant areas. Thus, they may seem relatively unproductive. There will often be so many different problems to work on that it is difficult to know where to begin, and it is easy to get sidetracked. Treatment may be further complicated by long-standing drug and alcohol-related problems. Acting out may further complicate the picture. Because these clients are also likely to be mistrustful, they are likely to terminate prematurely.

Therapy and Therapeutic Pitfalls

Establishing trust is difficult. These individuals are acutely sensitive to hostility. They put the therapist through various trust tests, as they find the intimacy of therapy disturbing; it engages their fear of vulnerability and abandonment. Dealing with the transference on an ongoing basis helps develop rapport as clients learn that questioning the therapist does not lead to abandonment. Existential discussions tailored to the clients' intellectual capacity, interwoven with discussions about general issues of trust and abandonment can be a gradual way to educate the client that not all relationships are exploitative and damaging. The therapist should be mindful and open to the transference and countertransference by remaining stable, predictable, nonjudgmental, and emotionally supportive without being rigid and distant (Kernberg, Selzer, Koenigsberg, Carr, & Appelbaum, 1989). Opposite-sex clients will tend to be seductive; however, interpreting the seductiveness tends to backfire, as it is likely unconscious. Maintaining boundaries without appearing cold or mechanical is the best approach (Gabbard & Horowitz, 2009). A

goal of long-term therapy is repairing damaged identity and self-esteem. Schema therapy has been demonstrated to be effective for these individuals (Bricker & Young, 2004). Short-term therapy should focus on teaching clients not to act out in destructive ways using specific advice and practical problem-solving approaches. These clients have difficulty experiencing empathy for what they experienced as children, so one therapeutic strategy is to have them role play one of the cruel experiences they suffered as children. This would need to be done gradually, being mindful that as the 4-8 individuals become aroused, they may lose control. This process uses identification with the aggressor as a way to first engage their hostile self-hatred before engaging self-empathy as the recipient of hostility. Boundaries are important, as this often reflects a borderline personality organization. At the same time, the therapist should not appear cold and rejecting, replicating their childhood history. (Levak, Siegel, Nichols, & Stolberg, 2011)

Treatment and Self-Help Suggestions

1. Work with your therapist to recall any childhood experiences where you felt cruelly treated, controlled, and emotionally, sexually, or physically abused. As you revisit those experiences, see if you can develop empathy for yourself as that small child. You may notice that you stay numb and emotionally uninvolved, as if you're describing events that happened to someone else. This may be because you learned to "numb out" your feelings and shut them off to survive. These were adaptive responses at the time and were useful as a way of dealing with an impossible situation. In your therapy, reengage some of those "numbed out" feelings. Write to yourself as a child, or perhaps imagine that you are a parent to yourself as a child.
2. Work with your therapist to see if you can identify any "schemas" or themes that you developed to deal with childhood experiences.¹ Some common themes include the expectation you will lose anyone you get attached to, the belief that others will take advantage of you, or the belief that others will somehow hurt you or put you down. Work with your therapist in session to imagine a conversation with the person that feeling involves. Being able to express your emotions in the safety of the therapy setting can gradually help you learn new perspectives and challenge old schemas.²
3. Resilience building: When you find yourself in a dark mood, you may be experiencing some of the emotional memories of your difficult childhood. Try to shift your mood by focusing on what is positive. Cultivating gratitude is a way to enhance happiness and health³ and is something that can be easily practiced. Try keeping a gratitude journal: four times a week for at least 3 weeks, record what you are grateful for. You can also write a "Gratitude Letter" to someone who has had a positive influence on your

life. Write about what this person did for you and how your life turned out differently as a result. This exercise is most effective when you meet the person face to face to thank him or her. You can find more ideas about increasing your gratitude and other positive emotions at www.authentichappiness.com.

4. Attempt to not push people away with coldness, anger, and irritability. Learning to be emotionally vulnerable again will be an important part of your therapy. Work with your therapist to identify people you do trust, even if it is someone you aren't very close to. Realize that not one person will meet all your needs and that you might trust different people depending on the situation. Bolster your coping skills, and trust yourself to be resilient enough to weather the times when you feel let down.
5. Because you've learned to keep up an emotional wall, you may not be able to read how others are feeling. It is hard for you to feel empathy for others because you have put up such an effective wall. Empathy is a skill that can be practiced by listening and focusing on the other person's experience. By asking questions and then double-checking, you can improve your ability to read other people. Find out more about how empathy is an essential "people" skill in the book *Emotional Intelligence: Why It Can Matter More Than IQ* by Daniel Goleman (1997).
6. Notice when you have strong emotions that are followed by a sense of feeling alone, misunderstood, or vulnerable. Begin looking at emotions without a judgment attached; instead, see them as pieces of information about your world, clues about how to solve life's problems. For example, if you are hurt by your partner, see if you can gather any clues about why you feel that way; perhaps you are overwhelmed and would like to ask for help with a task.
7. Mindfulness involves paying attention to the present moment in a nonjudgmental way and fostering a quality of curiosity and openness.⁴ For more information on mindfulness exercises see www.mindfulnessstapes.com. You can begin by setting aside time to observe the moment without analyzing or judging it. Pay attention to the sight, sound, taste, smell, and feel of the experience. Engaging in a daily practice of mindfulness can help you manage powerful emotions.⁵
8. Avoid substance abuse as this may aggravate some of your angry, dark moods and may lead you to act in aggressive and inappropriate ways.

9. Although you may find it difficult, explore with your therapist how your sexuality may be mixed with aggression and how that might interfere with your sense of connection to the people you love.
10. Your therapist may use cognitive-behavioral techniques as a way to help you with the trauma of your childhood.⁶
11. Dialectical behavior therapy has been shown to be effective for your condition,⁷ so you could research any local practices offering it. A good self-help Web site is <http://www.dbtselfhelp.com/>.

¹ Schema therapy has been demonstrated to be an effective treatment for clients who expect and anticipate emotional rejection and criticism based on their own early childhood conditioning experiences.

Help clients first identify their particular schema (Bricker & Young, 2004), and then work to help them examine the early experiences that led to that belief. The next step is to challenge that idea and to help them examine whether it is true and whether it is helpful (Young, Klosko, & Weishaar, 2003).

² Schema therapy uses many of the same methods of cognitive behavioral therapy, but it adds imagery to uncover suppressed emotions and to highlight the ways that these fixed beliefs affect current relationships (Young, 1999).

³ In a study of 192 undergraduate students, Emmons and McCullogh (2003) compared three groups: one group wrote about gratitude, one group wrote about hassles, and the last wrote about neutral events. The gratitude group exhibited heightened well-being, more optimism, and fewer symptoms of physical illness.

⁴ Bishop et al. (2004) explain mindfulness as an acceptance of the present moment and a playful and curious awareness.

⁵ Mindfulness and compassion can play a powerful role in helping people who have traumatic backgrounds and perceived threats either from the external world (what others might do to them) or from their internal feelings of being overwhelmed by self-contempt or troubling memories (Gilbert & Tirsch, 2009). Orzech, Shapiro, Brown, and McKay (2009) studied the role of intensive mindfulness training on changes in psychological symptoms and found significant increases in well-being, selfcompassion, and resilience and decreases in anxiety after 1 month of mindfulness training.

⁶ Interventions that have the best empirical support for treating posttraumatic stress disorder are prolonged exposure therapy, some interventions, and trauma-focused cognitive-behavior therapy (Rubin & Springer, 2009).

⁷ Linehan (2000).

(Levak, Siegel, Nichols, & Stolberg, 2011)

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you are feeling emotionally empty, angry, sad, and distrustful of others. It is difficult for you to become emotionally close to others and to trust that you can be vulnerable and that others won't hurt you.

You see the world as a hostile place where people exploit and take advantage of each other, so you keep people at a distance, perhaps warning them to stay away from you by the way you dress and carry yourself. Perhaps through piercings or tattoos you let people know that you are someone that they should respect or fear. You can become quite hostile if you perceive others as disrespecting, threatening, or taking advantage of you. In some cases, people with your profile do not dress or act in an obviously rebellious or frightening manner. Rather, you maintain an emotional distance by treating others in a cool or aloof manner, and by finding ways to take advantage of them.

Your parents may have been cold, unavailable, or even cruel, so from an early age you learned to withdraw to protect yourself. Feeling unloved and unwanted, you found ways to be a survivor, manipulating others or becoming emotionally numb so you could not be hurt. No wonder you question all authority now, since you could not trust your parents to meet your needs.

Your profile suggests you may feel periods of emptiness, aloneness, and disconnection from others. At times, you may even feel paranoid, as if people are wearing masks and disguising how they really feel. When you are hurt, you lash out at others. Sometimes people with your profile mix aggression and sexuality, finding sweet and tender moments uncomfortable or even irritating. You may also medicate your empty, angry feelings with drugs and/or alcohol and, under the influence, you may become more volatile and mean, even to people you care about.

Explore with your therapist moments in your childhood where you felt rejected and alone. As a way of developing self-esteem, try to develop empathy for yourself as a child who felt rejected or abandoned. Avoid drugs and alcohol, especially when you are feeling angry or if you are experiencing paranoia. CBT could help you learn to manage some of your dark and negative moods by shifting your focus onto things that are positive in your life. When you experience tender or loving moments, avoid pushing the other person away. If you allow yourself to enjoy moments of emotional connection, it will help alleviate some of your empty, sad feelings. Medication could also help to soften the edges of the dark and paranoid feelings.

Feedback Statements—Elevated Profiles (T-Score > 65)

Strengths

Your profile reveals that you have a number of strengths. You are an independent, creative, and imaginative thinker.

Disconnected or Fears of Trusting

Currently, you appear to be feeling alone and disconnected emotionally from others, and it's hard for you to "read" what others are thinking and feeling. Feeling connected is difficult for you, perhaps because you're afraid that they will hurt or even be cruel to you. You may want loved ones to show you a great deal of affection to prove that you can trust them, but at the same time you'll push them away, afraid to let down your guard. You may be cold, aloof, or even hostile to people before they can reject or hurt you. Even when things are going well, you may feel a strange sense of disconnection, as if you're in a dream rather than engaged in life.

Self-Defeating or Self-Destructive

You may experience periods of dark moods where you suddenly feel alone and empty, and you may not know what caused the onset of the mood. During these times, you may feel angry and push people away. You may become annoyed and short-tempered and do things that are self-defeating or even self-destructive.

Inappropriate Affect

It may be hard for you to experience pleasure, so that even gentle and sweet moments seem to be happening to someone else rather than to you. You may experience odd emotions that well up at inappropriate times. Perhaps when someone is being nice to you or when something good is happening, you may find a sudden urge to say something unkind or even cruel. Odd associations may arise in your mind, interrupting moments that should be pleasant or even rewarding, or you may feel a strange sense of excitement when things go badly.

Sexual and Aggressive Fantasies

Some people with your profile confuse sexuality and aggression. In loving moments, you may find yourself fantasizing about aggressive thoughts. When you experience emotional and sexual connection with others it may inadvertently reengage the anger. It's important to discuss with your therapist if your angry thoughts involve actually hurting others.

Poor Relationship Adjustment or Unable to Trust

Becoming involved in a close personal relationship can be particularly stressful because it will bring up early memories of being rejected and cruelly treated. Even when people are complimentary or loving to you, it's hard for you to trust them. Letting down your guard and being intimate is so frightening that you may find ways to create distance from people you want to care about. When something comes up in your relationship that suggests conflict, you may choose to reject them before they can reject you. Being in a committed relationship is frightening, and this may lead to marital or relationship difficulties. Learning to like yourself, to have empathy for others, and to not

push people away will be an important part of your therapy.

Paranoid

At times, your distrust may become so intense that you feel a little paranoid. At these times, it's hard to know whom to trust, and you may misinterpret others' motives and feel that people are out to harm you.

Lifestyle and Background Feedback

Often, people with your profile grew up in environments where their parents were cold, controlling, rejecting, and cruel. From an early age you learned to protect yourself against hurt by keeping up a wall and not letting yourself be vulnerable. Perhaps you escaped into your own fantasy world as a way of avoiding the pain of your outside world. Now, you may find yourself daydreaming, perhaps creating angry fantasies as a way of letting go of some of the anger that often results when somebody has been badly treated. No wonder you don't trust and you won't let yourself experience tender moments. In fact, caring for people makes you feel so vulnerable, you demand they constantly prove their love and loyalty to you.

Normal-Range Feedback

Your profile is in the normal range. In fact, you show a number of solid strengths and abilities. You test as independent, nonconventional, and creative. You tend not to follow the crowd but instead seek your own solutions to problems. Periodically, you may find yourself withdrawing from people and having some difficulty trusting and letting go of emotional control. At these times, you may find it difficult to accept and emotionally open up to those you care about or to feel close and connected to others. During times of stress you may have a sense of foreboding and anxiety, as if the world is unpredictable, even dangerous, and that something bad could happen. You may occasionally be impulsive in ways that are self-defeating or self-destructive. Occasionally, you may experience moodiness, where you feel empty and alone but can't identify why.

(Levak, Siegel, Nichols, & Stolberg, 2011)

.48F Code

1. These elevations tend to be obtained by potential juvenile delinquents (Hathaway & Monachesi, 1958).
2. They also are found in emotionally disturbed adolescents.

3. When these elevations occur with a low 2 scale, the person is usually an aggressive, punitive individual who likes to arouse anxiety and guilt in others (Carson, 1969). Such people may end up in jobs where their behavior is socially approved, e.g., law enforcer, school disciplinarian, or over-zealous clergyman.

48/84, High F, Low 2 Code

In addition to the 48/84 characteristics, the low Scale 2 suggests the individual's sense of estrangement and alienation has become ego-syntonic. They tend to treat others as objects and often are aggressive, controlling, and quick to punish and lash out if they feel in any way mistreated. If of above-average intelligence, they can be narcissistically manipulative. Though some may complain of depression, their experience is more of a sense of existential emptiness, which reflects their distrust and alienation rather than depression. They have sexual difficulties, primarily with the confusion of aggression and sexuality, and can be quite exploitive of others. Some individuals with this pattern obtain a diagnosis of psychopathy. If Scale 7 is also low, then the lack of anxiety predicts a greater likelihood of psychopathy and un-socialized aggression.

TREATMENT

See treatment section under the 48/84 codes.

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you are currently feeling very alone and disconnected from others. People with your profile have often experienced childhoods where a parent was rejecting or even cruel. From an early age you learned to protect yourself by withdrawing into your fantasy world and not allowing yourself to feel vulnerable. It is no wonder that it is hard for you to trust others now, and it is difficult to let down your guard and allow people to get close to you. In some cases, people with your profile experienced physical and/or sexual abuse that left them feeling angry and unable to trust others. In these cases, the early abuse may have created some sense of confusion between sexuality and aggression. In other cases the sexual aggression combination is similar to what they experienced in early abuse. During times of stress, you may become preoccupied with aggressive or even frightening thoughts and your thinking may become disorganized. As stress builds, you may act out impulsively, doing something that others find disturbing, peculiar, or bizarre. Because of early neglect or abuse, you have difficulty loving yourself, so you may find it easier to be around people who live unorthodox or marginal lives rather than around people who are more conventional. Work with your therapist on how to recognize what you are feeling so that you can express feelings to others rather than withdrawing or acting out. Learn to recognize what others might be feeling so that you can respond to them with empathy. Perhaps as way of protecting yourself, you numbed your emotions, so that

sometimes others may see you as cold, aloof, and uncaring. Avoid chemical agents as way of medicating your inner emptiness. Drugs and alcohol may actually increase your tendency for impulsive and even violent or illegal behavior. Work with your therapist to develop empathy for yourself as a hurt, abandoned, or neglected child.

482/842/824 Codes

Distrust and alienation characterize this codetype, along with defeated depression, anxiety, and tension, difficulties with concentration and memory, and irritability. This codetype has many similar features to the 48/84, but with the addition of depression due to some recent loss or setback. Like the 48/84 these individuals have difficulties with intimacy and keep a protective distance from others. They demand a great deal of loyalty and reassurance from others but this has little soothing effect, as they distrust it when it is given. The individual with this codetype is intensely moody and is quick to be angry, irritable, and argumentative over small, perceived slights.

As with the 48/84 codetype, these individuals' mood swings may be seen by others as inappropriate and odd, often erupting without obvious provocation or significant stress. They can show breakdowns in reality testing. Episodes of paranoia tend to be diffuse rather than fixed and rational. When stressed, they act out, either lashing out against others, or withdrawing and being self-destructive. They are extremely sensitive to any demands placed on them, and are often resentful, bitter, and feel hopeless.

These individuals experience low self-esteem, anger, which can be turned inward or outward, and anxiety around emotional involvement. At times their responses to others can appear odd or bizarre. They can be unpredictably cruel and self-protectively angry. This profile is associated with severe marital discord. They have inner conflicts around sexuality, and they have difficulty expressing emotions in any modulated or adaptive way. Suicide attempts are common, as are other self-destructive and reckless behaviors.

1. This profile indicates a person who is distressed while at the same time hostile and distrustful. The person tends to be isolated and potentially suicidal (Lachar, 1974).
2. Marks et al. (1974) found the 44-2/8-4-2/8-2-4 pattern in a university hospital and outpatient clinic. A person with this profile tended to be distrustful of others, keeping them at a distance. The person usually was described as depressed, tense, irritable, and hostile. The Marks, Seeman, and Haller book should be consulted for further information concerning this profile.

Diagnosis

Psychosis 71%+	Schizophrenic/paranoid
Personality disorder 21%	Sociopathic/antisocial

Psychoneurosis 8%-

Mixed

Brain syndrome 0%

Rules

4, 8, and 2 above 70 Ts

4 minus 2 less than 15 T-scores

4 greater than 7 (or 7 minus 4 less than 5 T-scores)

8 minus 2 less than 15 T-scores

8 minus 7 more than 5 T-scores

8 minus 9 more than 10 T-scores

9 below 70 Ts

L and K less than F, F below 80 Ts

Most Descriptive

44. Is distrustful of people in general; questions their motivations (8.6) +

68. Keeps people at a distance; avoids close interpersonal relationships (8.6) +

17. Utilizes projection as a defense mechanism (8.4) +

70. Utilizes rationalization as a defense mechanism (8.4) +

87. Is afraid of emotional involvement with others (8.4) +

96. Genotype has paranoid features (8.4) +

85. Has inner conflicts about sexuality (8.2) +

56. Complains of weakness or easy fatigability (7.8) +

40. Genotype has schizoid features (7.6)

79. Is resentful (7.6)

83. Is argumentative (7.6) +

97. Is sensitive to anything that can be construed as a demand (7.6) +

5. Possesses a basic insecurity and need for attention (7.4) +

19. Is unpredictable and changeable in behavior and attitudes (7.4) +

26. Reacts to frustration intropunitively {i.e., punishes self} (7.4) +

14. Utilizes acting-out as a defense mechanism (7.2) +

55. Has feelings of hopelessness (7.2) +

57. Seems unable to express own emotions in any modulated adaptive way (7.2)

- 58. Tends to be ruminative and overideational (7.0)
- 65. Has an exaggerated need for affection (7.0)
- 75. Has inner conflict about emotional dependency (7.0)

Least Descriptive

- 42. Is "normal," healthy, symptom free (1.0) —
- 11. Is cheerful (1.4)
- 107. Would be organized and adaptive when under stress or trauma (1.4)
- 108. Has the capacity for forming close interpersonal relationships (1.4) —
- 49. Appears to be poised, self-assured, socially at ease (1.6) —
- 51. Exhibits good heterosexual adjustment (1.8) —
- 95. Accepts others as they are; is not judgmental (1.8) —
- 41. Has good verbal-cognitive insight into own personality structure and dynamics (2.0) —
- 9. Presents self as being physically, organically sick (2.2) —
- 37. Defenses are fairly adequate in relieving psychological distress (2.2)
- 59. Is socially extroverted (outgoing) (2.2)
- 63. Has a resilient ego-defense system; has a safe margin of integration (2.2)
- 7. Psychic conflicts are represented in somatic symptoms (2.4) —
- 30. Has "diagnostic" insight; awareness of the descriptive features of own behavior (2.4) —
- 67. Is able to sense other person's feelings; is an intuitive, empathic person (2.4)
- 105. Manifests hypochondriacal tendencies (2.6) —
- 21. Has multiple neurotic manifestations (2.8) —
- 25. Presents a favorable prognosis (2.8)
- 50. Has a need to affiliate with others (2.8) —
- 81. Is perfectionistic ; is compulsively meticulous (3.0) —

Personality Description

These patients have in common a general distrust of people, a suspicious questioning of their motivations, and a fear of emotional involvement with others. They are consistently perceived by clinicians as maintaining an emotional distance from people and avoiding close personal relationships. Notwithstanding this rejection of emotional ties, the 4-8-2 has an exaggerated need for affection, is weighted down with basic insecurity and needs for attention, and harbors conflict over emotional dependency. Described as resentful, irritable, moody, argumentative, and hostile,

these patients are emotionally inappropriate and given to ideas of reference. These are all characteristics which are consistent with the label "paranoid." Gilberstadt and Duker (1965, p. 76), in fact, use the diagnostic term "paranoid personality" in connection with these patients. That the defense mechanism of projection is rated quite high for these patients is also consistent with this clinical characterization. They are also judged high on "rationalization"; that is, they try to justify as logical what is clinically rated as "psychopathological." Evident also, is the tendency of these patients to "act out" and manipulate both objects and others. The difficulties revolving around interjudge reliability of psychiatric diagnosis may be illustrated here in that nearly three-fourths of our 4-8-2 patients are diagnosed paranoid schizophrenic rather than paranoid personality and yet gross or florid thought disorder is less salient and less prominent than in the mental status of patients yielding other profiles in which scale 8 predominates (e.g., 8-3, 8-6, and 8-9).

People with this profile are sensitive to anything that can be construed as a demand upon them. Inner conflicts about sexuality exceed in frequency even the high base rate of the population in general. No doubt, this is related to the unusually high frequency of endorsement of "single" marital status. Gilberstadt and Duker (1965) report a majority of their 4-8-2 patients to be unmarried, and in our sample, 50% are unmarried. Of those who are married, 70% report

discord. Clinicians observing and/or treating our 4-8-2 patients found their behavior to be erratic and unpredictable. Their ego controls are weak and they seem unable to express their emotions in any modulated or adaptive way. About 75% of these patients report histories of parental rejection or parental domination; none reported that their parents were affectionate during their childhood. Ten per cent of these patients were of illegitimate birth. Throughout their childhood, they were labeled as "behavior problems" and their school work was almost always below average; in fact, 35% had received only a grade school education.

TREATMENT

See also treatment section under the 48/84 codetype. Similar to the 48/84, these individuals often have disastrous early childhoods. Early parental rejection and/or domination are common, and very few report affectionate caretakers. Look for illegitimate births and a childhood in which they are labeled early as a behavioral problem, with school difficulties and education marred by truancy and absences. This profile can be understood as reflecting a childhood of being "born unwanted." Supportive rather than insight-oriented therapy is suggested, as the latter can be psychologically disorganizing. Structured life skill therapies are recommended to help the client manage basic life skills. Dialectical behavior therapy is useful to help them recognize and label their emotions and find effective ways to express them. Learning empathy is important to help them manage interpersonal intimacy. These individuals expect rejection from the therapist and, therefore, put the therapist through trust tests, perhaps unconsciously

seeking to replicate and repair their early rejection experiences with their caretakers. The prognosis is often guarded. Sedating antidepressants can be useful. Suicidality is a danger and should be monitored. Sometimes they become more self-destructive as the therapy begins to be effective.

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you are currently feeling quite depressed, sad, and trapped. It is hard for you to let down your guard and to trust others because you feel others will hurt you or let you down. People with your profile often grew up with parents who were cold or even rejecting and cruel. From an early age you learned that you needed to withdraw, not allow yourself to be vulnerable, and protect yourself from feeling abandoned. You may find yourself pushing people away before they can hurt you, withdrawing to avoid rejection. If you experienced parental neglect or cruelty, you may find yourself constantly on guard, anticipating that others are going to use you or take advantage of you. You may be quick to get angry if anyone makes demands on you, and you may expect others to show you a great deal of loyalty and support before you can trust them. If they let you down in any way, you tend to push them away or punish them, and it is hard for you to give them a second chance. During times of stress you may become quite despondent, and you may even feel that life is not worth living. When stressed, it can be hard for you to feel safe. You might find yourself getting preoccupied with how people are treating you, and whether they are criticizing or judging you, or trying to hurt you. During these stressful times, you may become confused, making it hard for you to know whether you are seeing things clearly. At these times you may lash out at others or yourself. Your therapist may suggest some medications to help you feel less anxious and to take away some of the painful, sad feelings. Work with your therapist to try to understand how others see you and what they are feeling. Because from an early age you learned to numb yourself to protect yourself, it may be hard for you to “read” other people’s feelings and know what they are feeling. In therapy explore how you can recognize some of the emotions you’ve learned to switch off so that you can talk about your feelings. CBT, relaxation training, and learning to have empathy for yourself and others can be helpful.

486/846 Codes

In addition to the 48/84 codetype characteristics, the addition of Scale 6 increases the likelihood of paranoia and other disturbances in reality testing. These individuals are suspicious, moody, and can become violent and vindictive when threatened. A preoccupation with weapons and other reflections of self-protective paranoia would not be unusual. (See also 68/86 codetype.)

Description:

Usually very destructive family background, “world is a jungle”

489/849 Codes

Code-Type 4-8-9/8-9-4

Descriptors

Complaints

Legal difficulties, resentment, hostility, sexual aggression or confusion, unusual or bizarre or eccentric behavior and appearance, possible psychotic episodes, underachievement, substance abuse, occasional complaints of situational depression, problems with trust

Thoughts

Unconventional, bizarre, possibly psychotic, angry, sexual aggression, preoccupied, disorganized, sadistic, vindictive

Emotions

Cold, apathetic, lacking in empathy, resentful, angry, sadistic, unstable, moody

Traits and Behaviors

Unempathic, can be charismatic, manipulative, nonconformist, sadistic, predatory, angry, acting out antisocially, sexual aggression or confusion, attention seeking, bizarre, demanding

(Levak, Siegel, Nichols, & Stolberg, 2011)

Therapist's Notes

Normal-range profiles have many of the 4-8-9 code-type attributes but at a lower level of expression. They are excitement seeking and adventurous and question the established way of doing things. They are independent, self-reliant, and think "outside the box." They can lack empathy, can be self-centered and impulsive, and can act out. At higher elevations, the 4-8-9 profiles combine the angry, rebellious, reckless behavior and possible charisma of the 4-9 profiles with the alienated coldness and instability of the 4-8 profiles. The 8-9 component adds hypomanic volatility and grandiosity to the possible thought disorder and mental confusion of Scale 8. Taken together, the 4-8-9 profile suggests individuals whose reality testing alternates between organized, driven grandiosity and hypomania, aggressiveness, and cognitive slippage. Therefore, acting out can be dangerous because it contains organized, coherent features as well as elements of a thought disorder. These individuals can be charismatic and can be seen as

exciting, adventurous, and risk taking, and they can sometimes have enough credibility to lead others into antisocial acts. Charles Manson is the most famous individual with this profile (Phillip Marks, personal communication, March 1990).

Intelligent and socially skilled 4-8-9 code types can rise to positions of prominence and power, although their impulsive and hasty self-defeating behavior eventually leads them into trouble. When 4-8-9 individuals commit crimes, they often planned poorly and appear senseless, even self-destructive. Substance abuse is common, and it aggravates their impulsive and odd behavior. At times, thinking can become loose and autistic, if not overtly psychotic. The profile suggests individuals who lack empathy, are poorly socialized, and respond to frustration with impulsive hostility and cruelty. They sometimes confuse sexuality and aggression; this code type can be implicated in sadistic and sexual homicide. Although these individuals can experience depression, it is an alienated sense of dysphoria and disconnection rather than a sense of communicative sadness. They gravitate toward exciting, adventurous, and risky behavior, perhaps as a way of seeking emotional stimulation. If confronted, they can be menacing and sadistic. They resist authority and, in their organized phase, can be extremely manipulative and ruthless. Not all 4-8-9 code types will act out antisocially, although the propensity for doing so is high. They will, however, exhibit social adjustment problems and interpersonal difficulties characterized by distrust, alienation, difficulties with communication, and lack of empathy. In an interview situation, they can be charming and appear relaxed but, when pushed or confronted, can quickly become argumentative and hostile. They tend to project their own tendency to manipulate onto others. They are vindictive when crossed. Their interpersonal style reflects their underlying potential for explosive anger. People often respond with anxiety or fear to the individual with a 4-8-9 code type and instinctively maintain a safe distance.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Elevations on Scale 9 add energy and impulsiveness as well as surgent self-confidence to 84/48 codetype descriptors. This increases the likelihood of acting out in unsocialized, aggressive, and even cruel ways. Behavioral agitation and sudden combative or violent behaviors are suggested with this codetype. These individuals can be quite charismatic and attractive initially, but also grandiose, manipulative, and emotionally unstable. Charles Manson is a good example of a 489 personality. In the 1960s, he persuaded a group of upper class followers to engage in a drug fuelled murder spree targeting Los Angeles socialites in an attempt to start a race war. Superficially, people with this codetype are often seen as exciting and adventurous because of their charisma. The stereotype of a gang member, such as a Hell's Angel, also fits the 489/849 code-pattern description. These individuals can be predatory, sadistic, and frightening. They resist being controlled, lack empathy, and can quickly become ruthless and coldly violent. They often dress in unusual or bizarre ways, reflecting their alienation, using fear or disgust as a way to keep others

at an emotional and physical distance, yet draw attention to themselves. Often these individuals exhibit a history of verbal and physical aggression. Alcoholism and/or drug use are common and increase the possibility of unsocialized, poorly thought through behavior. If Scale 0 is low, the 489 can often be a charismatic leader, although their impulsive and bizarre ideology may eventually become self-destructive.

These individuals are sensitive to criticism or any threats to their self-esteem. If *K* is low, they can respond violently to threats. If *K* is elevated, their angry retaliation can be cunningly organized and vindictive. Sexuality and aggression tend to be fused, and they often have sadomasochistic and impersonal sexual relationships. They are often promiscuous.

Distrust is a primary feature of the profile. They fear emotional closeness and lack empathy. Projection, rationalization, externalization, and acting out are primary defenses. Numerous tattoos, body piercings, and flamboyantly bizarre clothing serve to draw attention to themselves while they keep others at a distance. Even if bright or educated, these individuals have poor and uneven achievement because of their bad judgment and impulsive behavior.

Lifestyle and Family Background

As children, these clients were often treated with hostility and coldness. Childhood histories suggest punitive, controlling, and cruel parenting. As a result, they develop resentment and anger toward family members and a damaged self-esteem. They tend to be self-defeating and self-destructive. Early poor school performance, reflecting the beginning of conflicts with authority figures, is common. They can experience occasional depressive episodes, in part because of their inability to develop a coherent identity, sense of purpose, or emotional bonds with others. These episodes reflect estrangement and emptiness rather than communicable sadness. As adults, these clients can exhibit uneven performance toward goals, often giving up even as they are getting ahead. They can impulsively change careers, identities, and life situations in ways that strike others as unusual and self-destructive.

(Levak, Siegel, Nichols, & Stolberg, 2011)

4-8-9/4-9-8/8-4-9/8-9-4/9-4-8/9-8-4

o Like 4-6-9 but less organized and more charismatic, grandiose, exploitive, unstable, and chronically hostile. May be menacing, predatory, and sadistic. Severe disidentification with authority; empathy defects; may be cold, extremely manipulative, ruthless, and prone to violence. Unusual or bizarre dress and grooming may be used to attract attention or to keep others at an emotional or physical distance. May be psychotic and disorganized. Look for history of underachievement and poor socialization if not brutalization; criminality, assault, and substance abuse. Check:

AGGR, RC9. See 4-8/8-4; 4-9/9-4; 8-9/9-8.

1. A person with a 4-8-9 profile may have a history of repeated aggression in situations where others get hurt. These people typically do not realize how they hurt others (Caldwell, 1972).
2. When a male has this profile, he may be violent but has charisma and vitality (Caldwell, 1972).
3. Highly aggressive males have the 4-8-9 scales as high points (Butcher, 1965).
4. When the 2 scale also is elevated (but not necessarily the next highest scale after the 4, 8, and 9), people talk about depression and tend to manipulate others so that they can get their own way (Caldwell, 1972).

Modifying Scales

- When Correction (K) and Ego Strength (Es) are elevated, the 4-8-9 code-type's behavior is more controlled and possibly dangerous. The clients are effective at masking their underlying thought disorder, cognitive slippage and their manipulation of others.
- When Scale 2 is elevated, the clients will complain of depression and despondency, but it is more a sense of hopelessness and angry defeat than physiological depression.
- When Scale 5 is in the feminine direction, the acting-out behavior may be more sexual in nature.
- When Scale 6 is elevated, the likelihood of paranoid and bizarre behavior increases. The possibility of psychotic episodes also increases. This is especially true if Ideas of External Influence (Pa1) is elevated.
- When Poignancy (Pa2) is elevated, the 4-8-9 is extremely sensitive to being disrespected or rejected and could be punitive and vindictive in return.
- When Bizarre Mentation (BIZ) or Psychoticism (PSYC) or Aberrant Experiences (RC8) is elevated, the possibility of psychotic episodes increases. The likelihood of disorganized and bizarre acting out increases.
- Typically, Cynicism (CYN) will be elevated, reflecting the underlying distrust associated with this profile.

- Negative Treatment Indications (TRT) would typically be elevated, reflecting distrust toward authority figures and mental health professionals.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Male

Low 0 Father conflict, lacks knowledge or information, lacks academic motivation, aggressive or belligerent. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, shyness in the interview, being nonresponsive or nonverbal, being nonverbal or a nonrelator, indecisiveness.

Low 2 Aggressive or belligerent.

Low 6 Rationalizes a great deal.

Nothing Low Indecisive, unhappy, worries a great deal, insomnia, confused.

- Note: Scale 9 coded high was infrequently associated with indecisiveness and worrying a great deal.

Female

Low 0 Depressed, insomnia, restless, confused, overprotective mother, home conflict, socially extroverted, vague goals, lacks academic drive, marriage oriented, verbal, 8+ conferences, resistant in the interview.

- Note: Scale coded low was infrequently associated with depression, confusion, home conflict.

Low 1 Depressed, insomnia, restless, confused, overprotective mother, home conflict, socially extroverted, vague goals, verbal, 8+ conferences, resistant in the interview.

Low 2 Depressed (48), insomnia, exhaustion, restless, confused, overprotective mother, home conflict, socially extroverted, vague goals, verbal, 8+ conferences, resistant in the interview.

- Note: Scale 2 coded low was infrequently associated with confusion and home conflict.

Low 3 Depressed, insomnia, restless, confused, overprotective mother, home conflict, socially extroverted, vague goals, verbal, 8+ conferences, resistant in the interview.

Low 5 Depressed, insomnia, restless, exhaustion, anxieties, confused, indecisive, overprotective mother, home conflict, rebellious toward home, socially extroverted, lacks skills with the opposite sex, vague goals, distractible in study, verbal, 8+ conferences, resistant in the interview, wants answers.

- Note: Scale 5 coded low was infrequently associated with resistance in the interview.

Low 6/7 Depressed, insomnia, restless, confused, overprotective mother, home conflict, socially extroverted, vague goals, verbal, 8+ conferences, resistant in the interview.

Nothing Low Depressed, insomnia, headaches, restless, confused, overprotective mother, home conflict, mother conflict, father conflict, sibling conflict, socially extroverted, lacks skills with the opposite sex, vague goals, verbal, 8+ conferences, resistant in the interview.

(Drake & Oetting, 1959)

TREATMENT

Childhood histories often reveal abusive, rejecting, and cruel parenting. They have often been identified as the “bad apple” within the family. As an adaptive response they may have learned the role of a flamboyant rebel with “nothing to lose” by resisting authority. These individuals can be quite intimidating to the therapist since they are confrontational, argumentative, and lack empathy. They rarely seek help unless experiencing legal or interpersonal difficulties that require them to seek treatment. Sometimes they can benefit from a process of developing self-empathy, understanding that their angry independence makes sense given a childhood in which they had no one to turn. Describe them as highly energetic, charismatic individuals who have learned the role of an angry survivor as an adaptation. Help them realize how surges of energy can lead to impulsive, self-defeating behavior. Using cognitive behavioral techniques, teach them to recognize their feelings of intense, exciting, disorganized energy, and rehearse with them how to self-calm and not move into action in response to surges of energy. During therapy sessions, work on transference and counter-transference once trust is developed, explaining to them how they can be frightening, and explore with them how their humiliation of people can have negative long-term consequences for them. They are sensitive to any demands, so explore with them how these “hot buttons” come from childhood experiences with a rejecting, authoritarian caregiver. They have difficulty modulating their emotions, so techniques to help them vent rage can be dangerous unless they learn how to “bring themselves down” when they are highly aroused. Self-esteem building and reparenting kinds of therapies in which the therapist can play the role of the “good parent,” while still setting limits, can be useful. Once a therapeutic relationship has developed, DBT can be useful to help them identify and express emotions.

Therapy and Therapeutic Pitfalls

Typically, 4-8-9 code types do not seek therapy. Usually, they are referred because of problems with the legal system or interpersonal difficulties related to their aggressive, acting-out, and addictive behavior. 4-8-9 code types are extremely distrustful and expect the therapist to be manipulative and uncaring. It is difficult for them to open up and to articulate their feelings and thoughts in any meaningful way. Obtain a history to ascertain the depth of early emotional, physical, or sexual abuse. Therapy should focus on helping clients recognize how their emotions can be disorganizing and can lead to impulsive, self-defeating, or aggressive behavior. Cognitive slippage during therapy, especially with hostile content, signals severe stress. Typically, limits are needed and will be challenged often. At such times, a sense of humor, but firm limits noticing the clients’ manipulations, without sternness, is effective. Insight therapy is generally contraindicated, as it might be disorganizing. To begin a process of gradual socialization, address ways that their aggressive stance and bizarre clothes are effective in keeping people at a distance but have negative

side effects. It is important to determine the strength of the clients' ego controls. Therapists should be supportive and reassuring while maintaining boundaries to create corrective socializing experiences that will enhance the client's social skills, self-awareness, and empathy. Substance abuse counseling is often needed. Treatment strategies to help them manage and modulate their impulses could be useful. They are often quite charming, engaging, and even endearing, but can quickly become hostile and demanding, especially if they feel in any way mistreated, disrespected, or scolded. Take hostile threats seriously. Although rarely suicidal, when feeling punished or trapped the Scale 9 mania can switch to Scale 2 depression and resulting self-destructive behavior.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Treatment and Self-Help Suggestions

1. Work with your therapist to recall childhood experiences where you felt cruelly treated, controlled, and emotionally or physically abused. As you recall those experiences, see if you can develop empathy for yourself as that small child. You may notice that you stay emotionally uninvolved, as if you're describing events that happened to someone else. This may be because you learned to "numb out" your feelings and to shut them down to survive. These were adaptive responses and useful as a way of dealing with an impossible situation. In your therapy, reengage some of those numbed out feelings. Write to yourself as a child, and include what you would do differently if you had been the parent.
2. In your therapy sessions, see if you can identify any "schemas" or themes that you developed in dealing with childhood experiences.¹ Some common themes include the expectation you will lose anyone you get attached to, the belief that others will take advantage of you, or the belief that others will somehow hurt you or put you down. Work with your therapist in session to imagine a conversation with the person that feeling involves. Being able to express the emotions in the safety of the therapy setting can gradually help you learn new perspectives that can challenge these old schemas.²
3. Resilience building: Whenever you find yourself in a dark mood, remember it's probably because you're experiencing some emotional memories of your difficult childhood. Write down a list of positive things in your life right now, and try to move away from the mood by focusing on what is going well. Cultivating gratitude is a good way to enhance happiness and health³ and something that can be easily practiced. Try keeping a gratitude journal: four times a week for at least 3 weeks, record the things you are grateful for. You can also write a "Gratitude Letter" to someone who has had a positive influence on your life. Write about what the person did for you and how your life

turned out differently as a result. This exercise is most effective when you meet the person face to face to thank him or her. You can find more ideas about increasing your gratitude and other positive emotions at www.authentichappiness.com.

4. Attempt to not push people away with coldness, anger, and irritability. Discuss with your therapist how you might become more trusting of others and how you put people through impossible trust tests before you can let down your guard with them. Learning to be emotionally vulnerable again will be an important part of your therapy. Work with your therapist to identify people you do trust, even if it is someone you aren't close to. Realize that one person will not meet all your needs and that you might trust different people for your different needs. Bolster your coping skills, and trust yourself to be resilient enough to weather the times when you are let down.

5. Talk to your therapist about how you will put your therapist through a trust test, and work out how that test can be passed.

6. Because you've learned to keep up an emotional wall, you may not be able to read how others are feeling. Ask people how they are feeling, and believe them, even though it is hard for you to feel empathy for others because you have put up such an effective wall. Empathy is a skill that can be practiced by listening and focusing on the other person's experience. By asking questions and then double-checking, you can improve your ability to read other people. Find out more about how empathy is an essential "people" skill in the book *Emotional Intelligence: Why It Can Matter More Than IQ* by Goleman (1997).

7. Notice when you have strong positive emotions that are followed by a sense of being alone, vulnerable, or even angry. Learn to allow the positive emotions to linger. See if you can begin to look at feelings without a judgment attached; instead, see them as pieces of information about your world, clues about how to solve life's problems. For example, if you feel hurt by your partner, instead of feeling hopeless or alone see if you can gather any clues about why you feel that way: perhaps you're feeling overwhelmed and would like to ask for help with a task.

8. Mindfulness involves paying attention to the present moment in a nonjudgmental way and fostering a quality of curiosity and openness.⁴ For more information on mindfulness exercises see www.mindfulnessstapes.com. You can begin by setting aside time to observe the moment without analyzing or judging it. Pay attention to the sight, sound, taste, smell, and feel of the experience. Engaging in a daily practice of mindfulness can help you manage powerful emotions.⁵

9. Avoid substance abuse, as this may aggravate some of your angry, dark moods and may contribute to you acting in aggressive and inappropriate ways.

10. Although you may find it difficult, explore with your therapist how your sexuality may be mixed with aggression and how that might interfere with your sense of connection to people you love.⁶

¹ Schema therapy has been demonstrated to be an effective treatment for clients who expect and anticipate emotional rejection and criticism based on their own early childhood conditioning experiences.

Help clients first identify their particular schema (Bricker & Young, 2004), and then work to help them examine the early experiences that led to that belief. The next step is to challenge that idea and then to help them examine whether it is true and whether it is helpful (Young et al., 2003).

² Schema therapy uses many of the same methods of cognitive-behavioral therapy, but it adds imagery to uncover suppressed emotions and to highlight the ways that these fixed beliefs affect current relationships (Young, 1999).

³ In a study of 192 undergraduate students, Emmons and McCullogh (2003) compared three groups: one group wrote about gratitude, one group wrote about hassles, and the last wrote about neutral events. The gratitude group exhibited heightened well-being, more optimism, and fewer symptoms of physical illness.

⁴ Bishop et al. (2004) explain mindfulness as an acceptance of the present moment and a playful and curious awareness.

⁵ Mindfulness and compassion can play a powerful role in helping people who have traumatic backgrounds and perceived threats either from the external world (what others might do to them) or from their internal feelings of being overwhelmed by self-contempt or troubling memories (Gilbert & Tirsch, 2009). Orzech, Shapiro, Brown, & McKay (2009) studied the role of intensive mindfulness training on changes in psychological symptoms and found significant increases in well-being, selfcompassion, resilience, and decreases in anxiety after 1 month of mindfulness training.

⁶ A useful resource for helping clients with sexual difficulties is *Treating Sexual Shame: A New Map for Overcoming Dysfunction, Abuse, and Addiction* (Hastings, 1998). *The Psychophysiology of Sex: The Kinsey Institute Series* (Janssen, 2007) is an excellent compendium of research into the underlying neurological, psychological, physiological, and affective processes regarding a wide range of sexual phenomena.

(Levak, Siegel, Nichols, & Stolberg, 2011)

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you are an energetic, charismatic, excitement-seeking, and adventurous individual. People have probably always seen you as having a “wild side.” You are not afraid to challenge authority, you hate to be controlled, and you enjoy the role of a colorful rebel. You have high energy and are quite excitable. Your profile also shows that you have a quick temper, and that even though you can be friendly and fun, if people cross you or get in your way, you can quickly become irritable, angry, and even dangerous. People with your profile often grew up with parents who were cruel, rejecting, and unreliable. Perhaps from an early age you learned to protect yourself by resisting and perhaps even fighting authority. From a young age you may have learned to not let yourself be vulnerable or let people get close. Learning to numb yourself emotionally may have protected you from being hurt, but it also meant that you “switched off” your ability to feel other people’s feelings and have empathy for them. When somebody hurts your feelings or treats you with disrespect, you may become vindictive, hostile, even cruel, and treat them the way you were treated. When you get excited, your emotions can get the better of you and you might do impulsive and even bizarre things. Because you’ve learned to protect yourself against being hurt, you may take advantage of people’s weaknesses and manipulate them to get what you want. It is easy for you take advantage of people and manipulate them because you see the world as a “dog eat dog” place where, unless you’re top dog, you’re going to be taken advantage of. People with your profile often use chemical agents as a way of feeling excitement. However, under the influence of chemical agents, you may do things that are dangerous, impulsive, and even violent. Work with your therapist to learn how to manage your high energy and your tendency to be impulsive. When you get excited, learn to recognize when your adrenaline is pumping and find ways to bring yourself down so you do not act out impulsively. Avoid drugs and alcohol. Work with your therapist to learn how other people feel so that you can develop a sense of empathy for them. Explore with your therapist any experiences as a child when you felt cruelly treated, or when you felt you had to lash out to protect yourself. Learn ways to talk about your feelings rather than impulsively lash out when you are angry.

Feedback Statements—Elevated Profiles (T-Score > 65)

Strengths

Your profile shows that you have some positive attributes and strengths. You have a great deal of energy, you can be charismatic, you’re not afraid to question the established way of doing things, and you’re not afraid to take risks. You’re able to be very spontaneous, creative, and independent.

Manipulative or Angry

Your profile also shows that you are going through life ready to confront, argue with, and manipulate people. It's as if you're afraid that if people have control or power over you they will abuse it and that if you let down your guard others will be cruel or will use their power over you. Sometimes you can be friendly, charming, and likeable, but if someone gets in your way, or tries to control you, you become angry, irritated, and perhaps even violent. That violence may be verbal or physical or both. You can experience periods where you feel relaxed, even easygoing, but your profile suggests that you're always a little on edge underneath, as if on guard for anyone humiliating, abusing, or taking advantage of you.

Problems With Trust

It's hard for you to allow people to get emotionally close. When you get involved in an intimate relationship, it might be frightening because you're afraid that the other person will have power over you. You seem to work hard not to let yourself care too much so that no one can hurt you. If you do let yourself care, you can become possessive and jealous, afraid that the other person can't be trusted. This may be because you grew up in an environment where people didn't trust one another and where you couldn't trust your parents to take good care of you. Now, when you are involved with someone, you feel vulnerable and insecure, and sometimes you even get paranoid and possessively jealous. It's hard for you to believe that anyone could really care for you and stay loyal, so you tend to become controlling and demanding.

Aggressive Sexual Fantasies or Hostility

Growing up with an abusive, cruel, and controlling parent, you learned to escape into your fantasy world to avoid getting hurt. Some of your fantasies may be violent, sexual, and even at times bizarre. You may experience aggressive, sexual fantasies where you or someone else is hurt. Some of your fantasies that mix aggression and sexuality may reflect the fact that you often experienced hurt and even violence from people who should have loved and protected you. Now, it's hard for you to let yourself be vulnerable and feel loving feelings without also experiencing anger and hostility. It's important for you to discuss these mixed emotions with your therapist.

Substance Abuse

You may abuse substances or have other addictive and self-destructive behaviors. When you use substances, some of your aggressive and sexual impulses may get the better of you, and you may do things that cause you difficulties with loved ones and authority figures. Under the influence of substances, you may become even more impulsive and perhaps quite hostile and aggressive, especially if you feel unfairly treated or disrespected. Some of your impulses may be quite violent and may take you by surprise.

Cold or Apathetic

It's hard for you to feel love and tenderness toward others. Moments that others see as sweet may leave you feeling empty, cold, and strangely distant. In moments when others might feel happy and loving, you protect yourself against letting down your guard. When people say positive or loving things to you, you suspect that they are being manipulative and somehow trying to get something from you. That's why you might feel apathetic when others expect you to be loving.

Moody or Vindictive

Although you can experience happy and even playful moods, you can quickly become angry and sometimes you may not know what caused it. At these times, you push people away, and it may be hard for you to talk about your feelings because you don't like to be seen as weak. As a child, you probably never had anyone you could turn to in frightening moments, so now when you feel anxious or hurt you get angry and ready to protect yourself. At these times, you might feel that people are wearing a mask and you may experience a cold emptiness because you are unable to read others or have sympathy for their feelings. When people hurt you, you can be quite vindictive and cruel towards them.

Nonconformist

Perhaps because of anger toward authority figures who mistreated you, you now have a tendency to be nonconformist and to argue against and resist authority figures. Sometimes you will create arguments for no good reason except to fight. Going through life arguing, resisting people, pushing people away, and not letting yourself Yourcare can be quite lonely.

Lifestyle and Background Feedback

Typically, people with your profile grew up in abusive situations where an authority figure was controlling, unfair, and unreasonable. From an early age, you learned to be ready to fight back and not to let your guard down. You protected yourself by being intimidating and manipulating people. To you, the world is a "dog-eat-dog" place where people can't be trusted and where you have to have control, power, and authority over others. You're afraid that if you let down your guard people will use your vulnerabilities and weaknesses against you.

Normal-Range Feedback (T-Score 50 to 65)

Your profile is within the normal range and reveals some positive attributes. You are excitement seeking, adventurous, and risk taking, and you are not afraid to question the established way of doing things. You tend to think outside the box, and you do things your own way; authority figures that come on too strong irritate you. People with your profile are often charismatic and easygoing, although underneath they may have difficulty trusting others and letting people get close. Being vulnerable, turning to others for emotional support, and allowing yourself to be intimate is difficult for you. When you do get involved, you may find ways to keep a distance from people and to protect yourself from getting hurt, perhaps by creating arguments or looking for others' faults. People with your profile are vulnerable to developing substance addictions. Perhaps you drink too much, use drugs, or have some other addiction that allows you to feel "alive." Although you may control your impulses for a period of time, your need to live on the edge can lead you to be reckless. People with your profile often do well in life until some lapse of judgment or hasty act leads to real problems.

(Levak, Siegel, Nichols, & Stolberg, 2011)

4892 Code

See the 44-9 combination, point 4, above.

Caldwell (1985) has found this to be a profile for people who are homicidal. The greater the difference between the 7 and 8 scales (the 7 scale being lower), the greater the potential for marked asocial behavior.

49/94 Codes

Code-Type 4-9/9-4

Descriptors

Complaints

Problems with authority, deficits in judgment and conscience, alcohol or drug use and related problems, difficulties with commitment and responsibilities, rebellious, undercontrolled, acting out, excitement and pleasure seeking, manipulative, some can be manic

Thoughts

Self-centered, manipulative, self-serving, excitement and pleasure seeking, narcissistic, egocentric, argumentative, hostile, rationalizing, difficulty learning from experience

Emotions

Enthusiastic, euphoric, angry, resentful, hostile, irritable, arousal seeking, lacking empathy, blaming, aloof, hedonistic, overreactive to frustration, absence of anxiety

Traits and Behaviors

Charismatic, confident, socially oppressive, undercontrolled, uninhibited, hypomanic, acting out, extroverted, irritable or angry, impulsive, immature, unreliable, irresponsible, self-indulgent, demanding, lying, untrustworthy, lacking normal inhibitions

(Levak, Siegel, Nichols, & Stolberg, 2011)

Therapist's Notes

This is a common code type, both in the elevated and nonclinical ranges. In the normal range, these profiles reveal self-confident, “big-picture” thinkers who have learned to be self-reliant and independent. They enjoy taking risks and are uncomfortable with too much structure or control. They may selectively report, overcommit, and be opportunistic and occasionally reckless. These clients are attractive, likeable people but are somewhat self-centered and subtly manipulative. Elevated 4-9s share a number of distinct attributes: the tendency to act out, poor emotional control, and difficulty with emotional trust and intimacy. The manner in which the 4-9 individuals act out can be quite different depending on social, cultural, and other personality variables such as IQ. In addition to the common features of the 4-9 personality type, we hypothesize four distinct clusters:

1. The controlled, calculating Machiavellian type. These individuals are poised, charming, and able to control their impulses effectively enough to be able to con most people. When these individuals act out, it is usually, carefully, thought through, calculating, self-serving, narcissistic, and devious. Like all 4-9 code types, they are emotionally aloof, lacking in empathy, and uninhibited by the normal restraining influences of guilt and anxiety. They can reach positions of power and use it for their own ends. They can be seductive, persuasive, likeable, and ruthless.
2. A second cluster within the 4-9 personality group is hedonistic, impulsive, and undercontrolled. They live in the moment, so they can be captivating, although their appeal tends to be short-lived due to their lack of impulse control. They are disorganized, often transparent, initially attractive, and haplessly in trouble with authority figures. This group has problems with substance abuse and hedonistic self-indulgence.
3. A third cluster is composed of rigid, authoritarian, and controlling types who gravitate to positions of authority and control over others. Individuals in this cluster, especially men but also women with Scale 5 scored in the masculine direction, often join the armed forces or police force, become fighter pilots, navy seals, or other professions that involve risk. They are attracted to professions where a rigid adherence to rules and regulations allows them control over their impulses through inflexible structure and gives them the opportunity to seek power over others. They have difficulties with emotional trust, can exhibit addictive behavior, are self-serving and narcissistic, and enjoy control and subjugation of others within a structured environment. They can achieve notoriety because of their ability to espouse rigid beliefs that appeal to basic fears and anxieties. They can be described as disciplined, quietly charismatic, strong willed, and determined. An example might be Joe Arpaio, the sheriff in Arizona who achieved notoriety by keeping prisoners in tents in 130 degree heat in the summer and serving unseasoned food: he was proud of his tough, nonsentimental approach.
4. The normal range 4-9 profile is the fourth cluster. This group exhibits many 4-9 characteristics without antisocial acting out. Like all 4-9 code types, they are somewhat underregulated, impulsive, and hedonistic and have difficulty with trust and empathy. However, they are able to manage their impulses well enough to take advantage of their competitive drive. Unencumbered by self-doubt, guilt, and anxiety, they are successful due to their ability to take calculated risks that often pay off. The character Gordon Gekko in the movie *Wall Street* represents this type. While generally operating within the law and exhibiting charisma and persuasiveness, these clients are able to blaze new trails with their abilities to “think outside the box.”

They are often bored with details yet controlled and poised enough to manage and capitalize on their persuasive abilities. This group may not actively lie but will tend to selectively report and distort the truth in self-serving ways. They are seen as flamboyant, charismatic, and adventurous but somewhat self-serving and subtly manipulative.

Despite the existence of these separate subtypes, all 4-9 code types are impulsive and excitement seeking and lack the inhibiting effects of anxiety and guilt. They tend to be secure but are not introspective, except as it serves them toward manipulative ends. Cleckley's (1955) well-known description of psychopathic traits closely parallels these descriptors of the 4-9 code type. Most of these individuals are able to role play compassion to manipulate others. They are adept at rationalizing their self-serving behaviors and are quick to externalize blame when things go wrong. Although capable of expending effort toward their own goals, they have difficulty maintaining responsibility unless they belong to the third or fourth 4-9 type. They are often initially charming because of their lack of social anxiety but tend to lose people's trust because of their impulsivity. Marks, Seeman, and Haller (1974) noted a unique feature of the 4-9 code type when retested with the MMPI under three distinct instructional sets. 4-9 code types admitted to a psychiatric hospital took the MMPI on admission, took it again as they projected they would be upon discharge from the hospital, and again at the actual time of discharge. Under all three conditions, these patients produced nearly identical 4-9 profiles; the leopard couldn't change its spots! (Levak, Siegel, Nichols, & Stolberg, 2011)

Lifestyle and Family Background

Our hypothesis is that this profile results from the interaction of genetic temperament and behavioral conditioning experiences. Parents often report the 4-9 code type child as active, energetic, and attention-seeking. Typically, these individuals were reared by parents who are authoritarian, unreasonable, and controlling and, at the same time, indulgent and narcissistic. Many 4-9 code types come from homes where the fathers were indifferent and permissive, whereas the mothers were dominating. From an early age, they learned to be "survivors," relying on their own emotional resources rather than turning to others for emotional support. We hypothesize that they learned to numb their emotions and, at the same time, to seek emotional stimulation as a way of counteracting their numbness. They are described as brighter than average, even though their school achievement is generally below average. The normal range 4-9 code type can be quite resilient and highly disciplined. (Levak, Siegel, Nichols, & Stolberg, 2011)

This is a common codetype and, while 49 individuals have many traits in common, not all 49 individuals are similar. It is a codetype commonly found among criminals, police officers, fighter pilots, high profile, risk-taking businessmen, and psychopaths. Individuals who obtain this codetype question authority and have difficulties with trust, emotional closeness, and perseverance toward long-term commitments. It is the most commonly occurring profile among reality TV applicants (sensation seekers). 49/94 individuals are narcissistic, charismatic, manipulative, power-oriented, and view relationships in terms of power and control. They are arousal-seeking, self-indulgent, and resent limits, rules, or regulations. They are vulnerable to substance abuse. They can be quite focused on their own goals and wants, and are quick to get irritated and angry if they feel frustrated. They can rationalize their behavior, externalize blame when things go wrong, and they have a poorly developed conscience. Many can be quite charming and socially skilled. The absence of anxiety, especially if Scale 7 is low, allows them to create an excellent first impression, and they are quite socially perceptive, using those skills to manipulate others. Many can be quite successful until their lack of attention to detail and their manipulations catch up with them. Uneducated, lower SES, 49/94 individuals experience fighting, marital and family conflict, and underachievement. Intelligent, educated 49/94 individuals, however, benefit from having more superficial poise and social control, and many can rise quickly to positions of authority and power. While some may not act out in blatantly antisocial ways, they nevertheless bend rules, blaze new trails, and sometimes make disastrously poor decisions. The financial crisis of 2008 may have been at least partly precipitated by a number of finance professionals who embody the typical educated 49/94 descriptors. Adolescents with this codetype have a low tolerance for frustration, experience conflicts with their caregivers and, while often successful in school early on, develop school difficulties as they reach middle and late adolescence. Adolescents, like 49/94 adults, are impulsive, reckless, provocative, and consequently experience problems with authority figures. Drug and excessive alcohol use are common both for adolescents and adults, as reflected by an often-elevated *MAC-R* scale. If *K* is above *T*-65, overtly antisocial behavior is less likely. These individuals have a veneer of social correctness, with subtle acting-out behavior underneath. If Scale 5 is in the feminine direction, it acts as an inhibitor of aggressive, antisocial acting-out behavior, muting the overt hostility of the 49, and suggesting sexual acting out and more socialized, self-indulgent, and narcissistic behavior. Some socialized 49/94 individuals become crusaders for a cause, reflecting their need for prominence and their socialized rebelliousness.

- o Marked disregard for social standards and values; antisocial behavior; poorly developed conscience, easy morals, fluctuating ethical values; wide array of delinquent acts (alcoholism, fighting, sexual acting-out, etc.)
- o Narcissistic, selfish, self-indulgent; impulsive; can't delay gratification of impulses; poor judgment; acts without considering consequences of acts; fails to learn from experience; does not accept responsibility for own behavior;

rationalizes shortcomings and failures; blames difficulties on others; low frustration tolerance; moody, irritable, caustic; intense feelings of anger and hostility which are expressed in occasional emotional outbursts

- o Ambitious, energetic; restless, overactive; seeks out emotional stimulation and excitement; uninhibited, extraverted, talkative; creates good first impression; superficial relationships; incapable of deep emotional Les; keeps others at emotional distance; beneath façade of self---confidence and security is immature, insecure, and dependent; usual diagnosis is antisocial personality or emotionally unstable personality

Individuals with this high point pair show numerous characterological difficulties and are described as being impulsive and irresponsible in their behavior, and trustworthy, shallow, and superficial in relation to others. They have easy morals, are narcissistic and hedonistic, but temporarily may create a favorable impression because they are internally comfortable and free from inhibiting anxiety, worry, and guilt. However, they are actually quite deficient in their role-taking ability. Judgment is likely to be poor and they do not seem to benefit from past experiences. Their limited ability to intuitively sense the feelings of others persistently handicaps their development of an effective adult role. Individuals with this high point pair have fluctuating ethical values and are prone to continue activities so long that they exceed proprieties, neglect other obligations, and alienate others. They possess a marked disregard for social rules and convention, and engage in behaviors with little or no forethought. Alcoholism, legal difficulties, marital problems, and sexually acting-out behaviors are common. Individuals with this high point pair are unwilling to accept responsibility for their own behavior and construct emotionally satisfying but irrational explanations for their difficulties. They will rarely become involved in psychotherapy. The most likely diagnosis appears to be some type of character disorder, with antisocial personality the most common.

Symptoms and Behaviors

Persons with 49/94 codes not only feel alienated and have antisocial tendencies, but also have the energy to act on these tendencies. They can be described as self-indulgent, sensation seeking, impulsive, oriented toward pleasure, irritable, extraverted, violent, manipulative, and energetic. They have poorly developed consciences, with a marked lack of concern for rules and conventions. Because they are free from anxiety, talkative, and charming, they can often make a good initial impression. However, their relationships are usually shallow because any sort of deeper contact with them brings out the more problematic sides of their personality. An investigation of history typically reveals extensive legal, family, and work-related difficulties (check the ASP/Antisocial Practices and WRK/Work Interference scales). The 49/94 code, when found in persons over age 30, suggests that this pattern is highly resistant to change. In adolescent males, it is associated with delinquency.

With a correspondingly low 0, this code is likely to reflect a person with highly developed social techniques, who will use these skills to manipulate others. Thus, he or she may be involved in elaborate, antisocial “con” games. If Scale 3 is correspondingly high, it decreases the chance of acting out. In these cases, the expression of hostility is likely to be similar to that of the 34/43 code in that it will be indirect and often passive-aggressive. When Scale 6 is elevated along with Scales 4 and 9, extreme caution should be taken because these individuals will be very dangerous and have poor judgment. Their acting out will often be violent and bizarre, and will appear justified to themselves because of strong feelings of resentment toward others. The most likely diagnosis is an antisocial personality, although caution should be made, especially when categorizing adolescents as these scales are more commonly elevated for both normal and abnormal adolescents. If Scale 8 is also high, it may reflect either a manic state or schizophrenia.

Personality and Interpersonal Characteristics

These individuals will often produce an external facade of being confident and secure, but underneath they will be immature, dependent, and insecure. They are likely to be narcissistic and incapable of deep emotional closeness. They will have a difficult time delaying gratification and often exercise poor judgment. Others will perceive them as being extraverted, talkative, uninhibited, restless, and needing emotional stimulation and excitement. Initially, they might make a good impression, but their antisocial style will soon become apparent. In particular, they will rationalize their own shortcomings and blame their problems on others.

o Stimulation seeking, intolerant of boredom and frustration; energetic and restless; disinhibited, undercontrolled, and emotionally unstable; rebellious and impulsive; socially aggressive; hedonistic, egocentric, and narcissistic. Irritable and hostile; overreactive to frustration, demands, and perceived threats/challenges to autonomy. Poorly developed conscience. Authority conflicts and disidentification with conventions, moral and ethical standards, rules, and regulations. Immature, irresponsible, and unreliable. Good social skills, disinhibition (boldness, brashness, insouciance), and absence of anxiety may create an early impression of charm and attractiveness. Selfish, exploitive (“con artist”), entitled, and amoral in relations with others; manipulates goods, services, and gratifications from others through superficial charm. Defends through acting out and rationalization. Long-term risk of accidental death related to risk taking or suicide. Look for a history of delinquency, adult antisocial behavior, and an overall failure to learn from punishing experience; underachievement, job losses, sexual promiscuity, fights, relationship instability, family and marital conflict, and substance abuse.

4-9/9-4

Individuals with this profile type tend to show marked disregard for social standards and values. They are usually viewed as antisocial; they appear to have a poorly developed conscience, easy morals, and fluctuating ethical values. It is not unusual to find that they have legal difficulties or work problems. They tend to have a wide array of problem behaviors, such as alcoholism, fighting, and sexual acting out.

In terms of personality features, the 4-9/9-4 patient is likely to be narcissistic, selfish, self-indulgent, and impulsive. These individuals tend to be viewed as irresponsible. They cannot delay gratification of impulses and show poor judgment. They also reportedly act out, without considering the consequences of their behavior. People with this pattern tend to fail to learn from punishing experiences. When in trouble, they rationalize their shortcomings and failures, blame their difficulties on others, and lie to avoid responsibility. They reportedly have a low frustration tolerance and are seen as moody, irritable, and having a

caustic manner. They are often angry and hostile and may have occasional emotional outbursts.

These patients are also energetic, restless, and overactive. They tend to seek out emotional stimulation and excitement. They are uninhibited, extraverted, and talkative in social situations. They often create a good first impression because they are glib and spontaneous; however, their relationships are usually superficial. They appear to avoid deep emotional ties. They are considered "loners" who keep others at an emotional distance. They usually present as self-confident and secure but are quite immature. The usual diagnosis for this profile type is antisocial personality.

The most salient characteristic of 49/94 individuals is a marked disregard for social standards and values. They frequently get in trouble with the authorities because of antisocial behavior. They have a poorly developed conscience, easy morals, and fluctuating ethical values. Alcoholism, fighting, marital problems, sexual acting out, and a wide array of delinquent acts are among the difficulties in which they may be involved. This is a common code type among persons who abuse alcohol and other substances. 49/94 individuals are narcissistic, selfish, and self-indulgent. They are quite impulsive and are unable to delay gratification of their impulses. They show poor judgment, often acting without considering the consequences of their acts, and they fail to learn from experience. They are not willing to accept responsibility for their own behavior, rationalizing shortcomings and failures and blaming difficulties on other people. They have a low tolerance for frustration, and they often appear to be moody, irritable, and caustic. They harbor intense feelings of anger and hostility, and these feelings are expressed in occasional emotional outbursts.

49/94 persons tend to be ambitious and energetic, and they are restless and overactive. They are likely to seek out emotional stimulation and excitement. In social situations they tend to be uninhibited, extroverted, and talkative, and they create a good first impression. However, because of their self-centeredness and distrust of people, their relationships are likely to be superficial and not particularly rewarding. They seem to be incapable of forming deep emotional ties and keep others at an emotional distance. Beneath the facade of self-confidence and security, the 49/94 individuals are immature, insecure, and dependent persons who are trying to deny these aspects of themselves. A diagnosis of antisocial personality disorder is usually associated with the 49/94 code type, although patients with this disorder occasionally are diagnosed as having a bipolar disorder.

Persons with this profile pattern show clear manifestations of psychopathic behavior, the hypomania seemingly energizing or activating the pattern related to scale 4. That is, these people tend to be overactive and impulsive, irresponsible and untrustworthy, shallow and superficial in their relationships. They are characterized by easy morals, readily circumvented consciences, and fluctuating ethical values. To satisfy their own desires and ambitions, they may expend great amounts of energy and effort, but they find it difficult to stick to duties and responsibilities imposed by others. In superficial contacts and social situations they create favorable impressions because of their freedom from inhibiting anxieties and insecurities. They are lively, conversational, fluent, and forthright; they enter wholeheartedly into games, outings, and parties, without being self-conscious or diffident. However, their lack of judgment and control may lead them to excesses of drinking, merrymaking, or teasing. They may be prone to continue activities so long that they exceed the proprieties, neglect other obligations, or alienate others.

Crook (1944) reported that women with this pattern made good prospects for the WAC. Wiener (1948b) indicated that this pattern was conducive to successful life insurance sales work. Drake reported that 49 patterns in college counselees were related to aggressiveness in the interview situation. Hovey found that these persons participated actively in group discussions. In another study Hovey (1954) suggested that a moderate elevation on scales 4 and 9 is an asset in impressing supervisors and winning social acceptance and approval. The patients with 49 patterns who sought help from an internist were reported by Guthrie to be suffering from episodic periods of tension, sweating and dizziness, and anxious distress. They had histories of acting-out behavior covering a wide range of troubles including marital problems, divorce, alcoholism, and illegitimate pregnancies. These considerations far outweighed their medical problems. According to Hathaway and Meehl (1951b), psychiatric patients with this pattern are primarily diagnosed as psychotic with manic disorders predominating. A significant subgroup were described as conduct disorders, but neurotic disorders were almost entirely excluded from this group. These patients were typically overactive; they were reported as extroverted, talkative, ambitious, and energetic, frequently irritable, and

occasionally violent. Drake found aggressive behavior to be particularly characteristic of college counselees with a 49 pattern when scale 2 was coded low. Both Marks and Seeman and Gilberstadt and Duker have 49 code types included in their subgroups (see Chapter 3 for the defining characteristics of this pattern in each system). Forsyth and Smith (1967) included a 49 group in their analyses of nursing students with various MMPI patterns who were rated by leaders after a series of group dynamics meetings. These girls were characterized as chatty, needing to be liked, anxious verbally and nonverbally, outgoing, distrustful, suspicious, manipulative, monopolizing group discussion, expressing personal problems, not allowing anger to be expressed, and intellectualizing. Watman (1966) examined the acting-out histories of 49 code prisoners and failed to find any particular proclivity for disruptions in prison routines for these prisoners. Sheppard, Fiorentino, and Merlis (1968) contrasted heroin addicts with 49 patterns with other subgroups of addicts in a narcotic addiction center in New York. These cases were characterized in Plutchik's (1962) schema as higher on the dimensions of incorporative, reproductive, orientative, and destructive emotionality. They were also appreciably lower on explorative and protective dimensions. (Dahlstrom, Welsh, & Dahlstrom, 1979)

Diagnosis

Personality disorder 80%+++	Sociopathic/emotionally unstable
Psychosis 15%-	Mixed
Psychoneurosis 0%	
Brain syndrome 0%	

Rules

4 and 9 above 70 Ts
 4 greater than 8
 4 greater than 9 (or 9 minus 4 less than 5 T-scores)
 6 less than 8
 9 minus 8 more than 5 T-scores
 2 and 7 below 70 Ts
 0 below 60 Ts
 F greater than L and K, F below 70 Ts

Most Descriptive

34. Undercontrols own impulses; acts with insufficient thinking and deliberation (8.8) ++

- 14. Utilizes acting-out as a defense mechanism (8.4) +
- 68. Keeps people at a distance; avoids close interpersonal relationships (8.2) +
- 98. Is egocentric; self-centered; selfish (8.2) + +
- 5. Possesses a basic insecurity and need for attention (8.0) + +
- 39. Genotype has psychopathic features (8.0) + +
- 52. Is self-dramatizing; histrionic (8.0) + +
- 61. Tends to be flippant both in word and gesture (8.0) + + +
- 64. Expresses impulses by verbal acting-out (8.0) + +
- 75. Has inner conflict about emotional dependency (8.0) +
- 80. Emphasizes oral pleasures; is self-indulgent (8.0) + +
- 97. Is sensitive to anything that can be construed as a demand (8.0) +
- 65. Has an exaggerated need for affection (7.8) +
- 70. Utilizes rationalization as a defense mechanism (7.8) +
- 62. Exhibits evidence of narcissism (latent or manifest) (7.6) +
- 93. Exhibits depression (manifest sad mood) (7.6)
- 20. Complains of difficulty in going to sleep (7.4)
- 22. Resents authority figures and typically has impulses to resist or derogate them (7.4) +
- 36. Has a rapid personal tempo; thinks, talks, moves at a fast rate (7.4) +
- 73. Is excitable (7.4) +
- 79. Is resentful (7.4)
- 78. Is irritable (7.2) 89. Is provocative (7.2) +
- 57. Seems unable to express own emotions in any modulated adaptive way (7.0)

Least Descriptive

- 63. Has a resilient ego-defense; has a safe margin of integration (1.2) —
- 91. Tends toward overcontrol of needs and impulses (1.2)
- 42. Is "normal," healthy, symptom free (1.8)
- 69. Gets along well in the world as it is; is socially appropriate in own behavior (1.8) —
- 104. Delusional thinking is present (1.8) —
- 41. Has good verbal-cognitive insight into own personality structure and dynamics (2.0) —
- 51. Exhibits good heterosexual adjustment (2.0) —
- 86. Is shy, anxious, and inhibited (2.0)

- 40. Genotype has schizoid features (2.2) —
- 29. Tends to avoid or delay action; fears committing self to any definite course (2.4)
- 37. Defenses are fairly adequate in relieving psychological distress (2.4)
- 45. Thinks and associates in unusual ways; has unconventional thought processes (2.4) —
- 107. Would be organized and adaptive when under stress or trauma (2.4) +
- 25. Presents a favorable prognosis (2.6)
- 71. Genotype has obsessive-compulsive features (2.6)
- 106. Has grandiose ideas (extreme is delusions of grandeur) (2.6)
- 48. Fears loss of control; cannot "let go" even when appropriate (2.8)
- 67. Is able to sense other person's feelings; is an intuitive, empathic person (2.8)
- 100. Obsessive thinking is present (2.8) —
- 30. Has "diagnostic" insight; awareness of the descriptive features of own behavior (3.0)
- 49. Appears to be poised, self-assured, socially at ease (3.0)
- 95. Accepts others as they are; is not judgmental (3.0)

Personality Description

To understand the 4-9 type, it helps to have some grasp of what Meehl (1972, p. 139) calls a "theory-sketch" of the basic psychological structure. For one thing, it is important to distinguish between the characteristic life history of delinquency and/or persistent antisocial behavior, and the personality construct. The point here is that people get labeled legally as delinquent or become entangled with the law for psychologically different reasons. In our patient group, as in others, the 4-9 individual is likely to be diagnosed as an "antisocial personality"—the earlier terms are sociopathic or psychopathic personality. Whether for primarily constitutional genetic reasons or as a result of a learning history (and these are unlikely to be mutually exclusive since the 4-9 personality is a phenotype resulting from submitting an endowed genotype to a learning history) the 4-9 individual appears to have an abnormally low capacity to experience anxiety or stress. This, in turn, leads to a deficiency in acquiring what are characterized as ego and superego controls normally developed during the socialization process and induced, at least in part, by aversive stimulation; people who generate this profile just do not learn from aversive experiences. Consistently, they rate low on adjectives like tense, nervous, high-strung, anxious, shy, and inhibited. When they get into difficulty, they rationalize; always it is someone else's fault.

The 4-9 type is distinctive in that it is the only one which maintains its code under all instructional sets (admission, projected discharge, and discharge). In other words, on entering the hospital or when beginning outpatient treatment,

these patients obtain 4-9 profiles; when asked to take the test as they would like to be at the conclusion of treatment, the profiles are unaltered (though sometimes they are less elevated); and when they do, in fact, leave the hospital or conclude outpatient treatment, their profiles remain 4-9 and in general are still elevated. It is as though they are announcing: "I am a 4-9; I plan to remain a 4-9." And, in fact, they do! No other code type behaves in this way. The 4-9 seems incapable of controlling impulses and acts with insufficient deliberation and poor judgment. In psychoanalytic terms it might be said that while in most people the reality principle governs behavior, for these individuals the pleasure principle dominates. To have an impulse is to act it out where others might first monitor that impulse. The 4-9 is histrionic, self-dramatizing, egocentric, self-centered, selfish, narcissistic, and self-indulgent. Although some of them may react with (subjective) depression to being in a psychiatric hospital, (objective) depressive affect has a low incidence in these individuals. Indeed, they tend to be restless and have a rapid personal tempo. People with this profile appear incapable of establishing the kind of emotional contact and commitment which characterizes friendship. They keep others at a distance and avoid the ties of close interpersonal relationships. Nevertheless, they are perceived by clinicians as insecure, conflicted about emotional dependency, wanting if not demanding attention, and harboring exaggerated needs for affection. They are sensitive to anything that can be construed as a demand on them. Their rebelliousness is exhibited in their antagonism to and resentment of authority figures whom they characteristically deride and oppose. They are immature, resentful, easily irritated—though there may be a thin façade of sociability—and highly provocative people. Their quick antagonisms are often reflected in flippant manner, blatant manipulations, and in caustic comments. Seventeen per cent are reported to be homicidal. This type is the youngest of all codes studied (mean age of 28 years). As children, these patients were typically behavior problems and although they were quite bright and test intelligent (mean WAIS IQ 118), their school achievement was generally below average. Invariably, the 4-9 is an under achieved. Though deficient in judgment and in social learning, thinking is intact in the sense that thought disorder is absent as reflected in speech. Frequent or steady dating is common for people with this profile. Many do marry, but over one-third are later separated or divorced, and two-thirds have extramarital relations. Marital discord is indeed reported in 100% of the cases. Delinquency of some sort is to be expected; 56% of that reported was sexual in nature, 39% of these patients were described as amoral, and 17% took other forms—drug abuse or alcoholism both occurred in about 25% of the cases. It is interesting that while 11% of these patients were born illegitimately (the highest percentage of any type), 33% later gave birth to illegitimate children themselves, while another 22% had illegal abortions. Many 4-9's come from homes where the fathers were indifferent and permissive while the mothers were dominating and permissive. Seventeen per cent of their fathers and 6% of their mothers were reported to have been alcoholic. Eighty per cent of these patients received only psychotherapy, while 20% also received tranquilizers. Unfortunately, there is typically reported "no response" to treatment. When there is improvement, it is only minimal. Consistent with this is the

generally poor prognosis these patients receive. As many as 38% terminate treatment prematurely against their therapists' advice.

4-9 See also the 9-4 combination, pp. 224-225.

1. People with their highest scale elevations on the 4 and 9 scales tend to be arousal seekers. They must maintain excitement and will stir things up to get it (Carson, 1969, 1972). In contrast to people with high 4-8 scales (when poor judgment may get the person into trouble), the high 4-9 person seems to be seeking the excitement of the trouble. The 9 scale activates and energizes the feelings shown by the 4 scale.
2. The person with an elevated 4-9 profile may be self-defeating.
3. A marked disregard for social standards and values may exist (Graham, 1977). If this is true, the Re scale also will tend to be low.
4. The 4-9 pattern tends to characterize the following people:
 - a. Juvenile delinquents.
 - 1) However, accompanying high scores on scale 2, 5, 7, and 0 act as inhibitors of the delinquent behavior (Carkhuff et al., 1965).
 - 2) This pattern may disappear with age.
 - b. Convicts.
 - 1) Habitual criminals are higher on 4 and 9 than first offenders of the same age (Panton, 1962).
 - 2) With male adults, this tends to be a chronic fixed pattern.
 - c. Heroin addicts (Craig, 1984a). In a recent study 21% had the 4-9/9-4 profile.
 - d. School and college under-achievers (Brown & Dubois, 1974). This is especially true for males if the 5 scale is low, whereas high 5 acts as a suppressor to the under-achievement tendency of the 4-9 pattern (Drake & Oetting, 1959).
 - e. Students in trouble for college misconduct (Nyman & Le May, 1967).
 - f. Female college students with interpersonal difficulties but fewer intrapsychic problems (King & Kelley, 1977).

5. Lewandowski and Graham (1972) found that patients with an elevated 4-9 profile were younger at their first hospitalization than other patients. They also were irritable, angry, and easily annoyed. They became upset quickly if things did not suit them.
6. Gilberstadt and Duker (1965) found the 4-9 pattern in a VA hospital male population. A man with this pattern tended to be self-centered, moody, and irritable. He tended to be superficially friendly, but he had a low frustration tolerance. The Gilberstadt and Duker book should be consulted for further information concerning this profile.
7. In another study of VA hospital males, patients with this pattern were energetic, ambitious, and lively. They were emotionally unstable with asocial tendencies. They were impulsive and had difficulty controlling their impulses (Hovey & Lewis, 1967).
8. Marks et al. (1974) found the 4-9 pattern in a university hospital and outpatient clinic. A person with this pattern tended to be self-centered, under-controlled, insecure, irritable, and hostile. The Marks, Seeman, and Haller book should be consulted for further information concerning this profile.
9. Two recent studies (Gynther et al., 1973a; Gynther et al., 1973) also have found antisocial behavior such as excessive fighting and attempts to harm others for this pattern 4-9/9-4. Men with this pattern also tended to have a history of alcoholic benders. This description may not apply to Blacks who have a .4-9 profile.
10. Adolescents in treatment with the 4-9/9-4 pattern (Marks et al., 1974) were referred because of being defiant, disobedient, provocative, and truant from school. They usually had constant conflict with parents. However, they had many friends and were well liked by them. They were typically drug users. The Marks, Seeman, and Haller book should be consulted for further information concerning this pattern.
11. Megargee and Bohn (1979) found four profiles with this code type for a group of incarcerated criminals. Their book should be consulted for classification rules to distinguish among the profiles and for descriptions of the behaviors associated with them. This was the most common two point code for Group Able (83% of the group). The men in this group were happy-go-lucky and outgoing. They were charming, popular, and manipulative. They created a popular impression but were likely to get into trouble again when they got out of prison. Group Foxtrot also had this 4-9/94 combination (69% of the group) but also tended to be

elevated on the 8 scale. Their criminal behavior seemed to be symptomatic of pervasive psychopathology. They had extensive criminal records and were one of the most violent groups. They had poor prison adjustment and the highest recidivism rate.

12. This pattern was found in a group of male alcoholics. Also found were the 2-1-3, 2-4-7, and 8-7-6 combinations (Conley, 1981). In contrast to the other combinations, the 4-9 profile did not change with treatment.

13. College students with high points on these scales have lower grade point averages and higher dropout rates than would be expected according to their ability (Barger & Hall, 1964).

14. College counselees with these high points were rated difficult to deal with (aggressive and opinionated) by their counselors (Drake, 1954). Male clients also had conflicts with their fathers. Female clients had home conflicts, vague goals, lacked academic drive and were socially extroverted (Drake & Getting, 1959).

Description:

Do not profit from experience, ignore social standards, seek stimulation, are self-centered, have superficial and short relationships, narcissistic, impulsive, acting-out, intellectualize to excess, expect quick results from therapy

Possible Diagnoses:

Substance abuse, Pathological gambling, Rape, Psychopathy, Antisocial, Histrionic, Narcissistic, Sexual sadism, Socialized nonaggressive conduct disorder

Modifying Scales

- The Harris and Lingoes subscales will indicate whether impulse control problems, a lack of anxiety, guilt, and other moderating influences predominate. For example, one quarter of the Self-Alienation (Pd5) items implicate guilt feelings (#52, #82, #94), so a 4-9 profile could consist of elevations on alienation and family conflict, suggesting less likelihood of antisocial acting out.

- When Scale 2 is elevated, rule out a bipolar disorder. In the absence of a history of depression and manic episodes, Scale 2 elevations might reflect a recent setback due to careless behavior. In such situations, these persons will be moody, despondent, guilty, and angry. The 4-9-2 code types vacillate between pressured overactivity and self-defeating behavior.

- When Scale 3 is elevated, the self-serving behavior is covered with a veneer of social appropriateness. The 4-9-3 code type plays roles, flattering others and exhibiting charm and social grace while breaking rules in roundabout ways. Impulse pressures are better controlled but potentially dangerous, especially if Overcontrolled Hostility (OH) is elevated above a raw score of 18.
 - When Familial Discord (Pd1) or Family Problems (FAM) is elevated, the conflicts tend to be more within the family rather than against authority figures. This is especially true if Authority Conflict (Pd2) is not elevated. However, if Pd2 accounts for the largest share of the Scale 4 elevation, this predicts the likelihood of antisocial behavior. Elevations on Antisocial Practices (ASP) would tend to confirm this influence.
 - When Pd1, Social Alienation (Pd4), and Pd5 are elevated but Pd2 is not, the profile may reflect a more alienated individual experiencing severe transitional difficulties but without antisocial conduct.
 - The relative elevations of Scale 9 subscales describe the manifestations of the 4-9 personality type. Generally, all the subscales are elevated, reflecting that these individuals are opportunistic, hypomanic, not easily knocked off balance, and have an inflated ego. However, if Psychomotor Acceleration (Ma2) is not elevated, then the 4-9 behavior will be less hypomanic and more controlled and opportunistic.
 - One would expect Cynicism (CYN) to be elevated, reflecting the mistrust associated with this code type.
 - When Obsessions (OBS) is elevated, obsessions associated with vindictiveness, possessiveness, paranoid jealousy, or sexuality, may be present.
 - Rarely would one expect Fears (FRS) to be elevated.
- (Levak, Siegel, Nichols, & Stolberg, 2011)

Male

Low 0 Father conflict, aggressive or belligerent. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, shyness in the interview, being nonresponsive or nonverbal, being nonverbal or a nonrelator, indecisiveness.

Low 2 Aggressive or belligerent.

Low 6 Rationalizes a great deal.

Female

Low 0 Vague goals, lacks academic drive, marriage oriented, verbal, home conflict, socially extroverted.

- Note: Scale coded low was infrequently associated with home conflict.

Low 1 Vague goals, verbal, home conflict, socially extroverted.

Low 2 Vague goals, verbal, home conflict, socially extroverted.

- Note: Scale 2 coded low was infrequently associated with home conflict.

Low 3 Vague goals, verbal, home conflict, socially extroverted.

Low 5 Vague goals, verbal, home conflict, rebellious toward home, socially extroverted, lacks skills with the opposite sex, indecisive, anxieties, exhaustion.

Low 6/7/8/Nothing Low Vague goals, verbal, home conflict, socially extroverted.

(Drake & Oetting, 1959)

o **Check:** *FRS1* (low), *FRS2* (low), *BIZ2*, *ANG1*, *ANG2*, *CYN1*, *CYN2*, *ASP1*, *ASP2*, *TPA1*, *TPA2*, *LSE1* (low), *LSE2* (low), *SOD1* (low), *SOD2* (low), *FAM1*, *FAM2*, *AGGR*, *PSYC*, *DISC*, *RC4*, *RC9*, *Pd1*, *Pd2*, *Pd3*, *Pd4*, *Pd5*, *Pa1*, *Sc5*, *Ma1*, *Ma2*, *Ma3*, *Ma4*, *Si1* (low), *Si2* (low), *A*, *R* (low), *Re* (low), *GF* (low), *MAC-R*, *APS*, *AAS*, *MDS*.

TREATMENT

Typically, these individuals do not seek therapy unless they are required to do so, or their impulsive behavior has led to adverse consequences. They generally do not experience guilt or anxiety, and tend to externalize blame for their difficulties. They are rated low on adjectives such as tense, nervous, high-strung, anxious, shy, and inhibited. They have strong needs for immediate gratification. In psychoanalytic terms, these people are governed by the pleasure principle, and thus are described as self-indulgent, egocentric, and narcissistic. Although some do experience depression when confronted with the consequences of their behavior, it generally is of short duration and tends to not affect their subsequent behavior. Although not all 49/94 individuals are antisocial or lack enduring adult relationships, most appear incapable of establishing any kind of non-self-serving commitment to others. Some may achieve academic success and are often quite bright. However, many become underachievers because of their acting-out behaviors and lack of discipline. The profile predicts marital conflict and sexual acting out. Look for childhood histories of dominating, narcissistic caregivers who were at times unreasonably controlling and at other times highly indulgent. These individuals learned to both fear authority and disdain it. As an adaptive response, some may have learned to be “survivors,” numbing their vulnerable feelings and learning to manipulate others to get their needs met. Working on the transference on a continuous basis is important, as these individuals tend to project onto their therapist their own tendency to “play the game” in order to get their needs met. Address their ongoing relationship with the therapist and allow them to verbalize disdain for what they may perceive as the therapist’s values in order to keep them involved. Psychotherapy can help them learn how they developed a “survivor” role and, through cognitive behavioral techniques, teach them that their tendency to roleplay and manipulate others may have been adaptive at some point, but can cause them ongoing interpersonal difficulties. Helping them develop discipline toward long-term goals and using cognitive behavioral strategies to help them manage impulse control can

also be useful.

o **Treatment:** Rule out Antisocial Personality Disorder; mania; and, rarely, paranoid syndromes. Lacks motivation for change but may seek to use therapy to manipulate others. Structured group therapy for antisocial behavior problems or substance abuse treatment may be helpful.

- Frequent diagnoses: antisocial personality (but use caution when categorizing adolescents, as these scales are commonly elevated for both normal and abnormal adolescents), manic state, or schizophrenia (with high 8).
(Groth-Marnat, 2009)

Treatment Implications

There are numerous difficulties encountered in therapy with individuals having 49/94 code types. They have difficulty focusing for any length of time and are constantly embarking on often irrelevant tangents. Despite this, they can be quite articulate. They have difficulty delaying gratification and usually do not learn from experience but are more concerned with self-gratification (often at the expense of others). They are frequently irritable and, if confronted by a therapist, will express their fairly extensive hostility. In addition, their typical coping strategy is through conning other people. Manipulation may involve a combination of charm laced with occasional belligerence. When this behavior occurs, it is advisable to confront it as soon as possible. Thus, treatment is likely to be slow, frustrating, and often unproductive. These individuals rarely volunteer for therapy but, rather, are referred by the court system or at the insistence of someone else (e.g., employer, spouse). External monitoring and motivation are usually required to keep them in treatment. However, because their anxiety level is quite low, they will not be motivated to change. Group treatment has been reported to be relatively helpful, and behavioral modification can often help them develop better coping styles. Despite this, termination is usually premature and associated with the client's feeling bored with the sessions, acting out, or a combination of the two.

Therapy and Therapeutic Pitfalls

MMPI-2 textbooks tend to be pessimistic about psychotherapy with 4-9 individuals. The therapist needs to be mindful of their beguiling, easygoing, and fluent interpersonal style, their ability to share vulnerabilities as a way of charming the therapist, and their tendency to flatter and make the therapist feel that they have won the clients' confidence. The 4-9 code types are artful role players; they understand human frailties and vulnerabilities and seek to exploit them. Deciding which of the subtypes the individuals belong to will be a prerequisite for therapy. It is

important to assess possible substance abuse and rule out a manic episode. These clients tend to do best with straightforward therapists who confront the clients when they are being manipulative and devious, but in a nonhostile way. The therapist has to win the 4-9 code types' respect. Giving them personality feedback—especially validating their high energy, ability to perceive others' weaknesses, and their view of the world as a “dog-eat-dog” place—can help win esteem, as does therapist perceptiveness and insight.

With a cold, Machiavellian type, teach them how to experience feelings and empathy for others. Help them see how their manipulations, though effective much of the time, can lead them into trouble as other people become aware of them. Help them understand how early emotional letdowns led to numbing of emotions as a way of protecting themselves. Coach them to recognize when they are taking self-defeating shortcuts or being cynically manipulative. For the hedonistic, disorganized type, help them understand how their lack of impulse control can be self-defeating and can lead to conflicts with authority figures and loved ones. This tends not to be effective until they have experienced a number of setbacks and are “ready” for change. Teaching empathy for others and helping them understand how others experience them is important, as they have little idea how they are viewed. Therapy with the third authoritarian personality type is difficult. They see weakness as a failing and have identified with the aggressor as a way of life. As parents, their rigidity can lead to depression or rebelliousness in their children. As a therapeutic strategy, validating their strength of character and willpower can build a therapeutic alliance. Eventually, find opportunities to help them experience moments of empathy for themselves as controlled discounted children might soften their rigid belief in the value of being punitive. If they can admit that they did not deserve the full intensity of parental domination and that they were not “all” bad, it could begin a softening of their identification with the aggressor.

For 4-9 code types in the normal range, foster their recognition that their inattention to detail and their organized self-aggrandizement can be transparent, and help them head off problems by focusing on details and avoiding impulsive, immediate gratification.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Treatment and Self-Help Suggestions

1. Explore your childhood with your therapist, recalling moments where you felt that you had to “numb yourself” to not experience vulnerable feelings. Work with your therapist to identify and “try on for size” different emotional states that most people feel. Emotional awareness begins with recognizing bodily sensations (e.g., clenched fists, racing heart, shallow breathing), then labeling the emotion, and finally linking the feeling to a precipitating event. The better you become at identifying your feelings, the more proficient you will be in taking corrective action, dealing effectively with others, and establishing greater intimacy.¹

2. Think about how you have learned a lifestyle of manipulation and control over others as a way of getting your needs met. Work with your therapist to detect any cognitive distortions or irrational beliefs that might lead you to use manipulation. Some examples of cognitive distortions and irrational beliefs are *negative fortune telling* (e.g., Never let others think they have the “upper hand” or they will take advantage of you); and *emotional reasoning* (e.g., If it works, do it, and worry about the consequences later). Your therapist can help you challenge these unproductive beliefs so that you can change this pattern of manipulative behavior.²

3. With your therapist, learn how to recognize times you are likely to be impulsive, and find ways to control your impulsive and reckless behavior. The practice of mindfulness is a way for you to channel your impulsive energy and to increase your focus and productivity. Mindfulness involves paying attention to the present moment in a nonjudgmental way and fostering a quality of curiosity and openness. For more information on mindfulness exercises see www.mindfulnessstapes.com. Engaging in a daily practice of mindfulness can help you redirect your attention instead of going on autopilot.³

4. Resilience building: It is not necessarily your impulsivity that is the problem in all situations: at times it means you are spontaneous, active, and social. These same traits become problematic only when you let things pile up or don't plan ahead. Some simple habits can help you stay efficient and harness your fun-loving, impulsive energy before it becomes a problem. Good planning involves the following:

- a. Problem definition: What am I dealing with? What is my first step?
- b. Focusing attention: Think of the steps; what do I do first?
- c. Strategy: First brainstorm, and then create goals.
- d. Self-evaluation: Correct any errors.
- e. Coping statements: I need to go slow. Don't worry—worry doesn't help.
- f. Reinforcement: Give yourself a reward.⁴

5. Discuss with your therapist your use of chemical agents, and determine whether it is aggravating your tendency to be impulsive. Collaborate with your therapist to weigh the pluses and minuses of making changes in your lifestyle.⁵

6. Because you have learned to numb your emotions, it's hard for you to feel empathy for what others experience. You tend to see vulnerable feelings as a sign of weakness, and something you can exploit. Work with your therapist to discover how other people feel so that you can expand your own emotional repertoire. Empathy is a skill that can

be practiced by listening and focusing on other people's experience. By asking questions and then double-checking, you can improve your ability to read other people. Find out more about how empathy is an essential "people" skill in the book *Emotional Intelligence: Why It Can Matter More Than IQ* by Goleman (1997).

7. Discipline yourself to follow through on details. Watch your tendency to impulsively promise people things without thinking through what it would take to actually deliver on your promises. There are many software applications for the computer and cell phone that will help you manage tasks, set priorities, and track important dates. A mobile phone application that turns your to-do list into a game can be found at <http://www.epicwinapp.com/>. Software packages can be found at <http://www.mylifeorganized.net/>.

8. Force yourself to tell the truth. Learning to be honest in the moment rather than to instinctively lie will eventually help you live a more stable, authentic, and connected life.

¹ A comprehensive guide to helping clients manage their feelings can be found in *Emotion Focused Therapy: Coaching Clients to Work Through Their Feelings* (Greenberg, 2002). The author makes a convincing case for the importance of emotions in the story of a client with impaired emotional responses due to brain damage; although his IQ was not affected, he decided to drive in a fierce snowstorm because he didn't experience the emotion of fear (p. 4).

² Over 50 types of distorted thinking have been identified (Beck, 1976; Ellis & Dryden, 1997; Leahy & Holland, 2000; Smith, 2002). A good source to help clients change distorted beliefs is *Mind Over Mood* (Greenberger & Padesky, 1995).

³ Researchers have debated about using mindfulness for hyperactivity and distraction for some time; there was a question about whether individuals with impulsivity could actually engage in mindfulness meditation exercises. Zylowska et al. (2008) conducted an 8-week mindfulness-training program for adults and adolescents with attention deficit hyperactivity disorder (ADHD). Subjects reported improvement in ADHD symptoms and they also had better test performance on measures of attention and impulsivity.

⁴ www.pent.ca.gov/pos/cl/str/basicformsofself-instructions.pdf.

⁵ Motivational interviewing (MI) has been demonstrated to be an effective approach for raising problem awareness and for facilitating change in clients who may be resistant, ambivalent, stuck, or not yet "ready" to make general behavioral changes and changes in drinking behavior in particular (Burke, Arkowitz, & Menchola, 2003; Miller & Rollnick, 2002). MI is particularly effective for people in the early stages of change, who are sensitive to being lectured and resent feeling forced to take action. General information can be found on the motivational interviewing homepage: <http://www.motivationalinterview.org>.

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you are an energetic, driven, excitement-seeking individual who hates to be controlled. You live in the moment, are not afraid to take risks, and at times you can be quite impulsive. People with your profile often grew up with authoritarian parents. From an early age you learned to be a “survivor,” relying on your wits and your own resources in order to get what you wanted. Perhaps one of your parents was very controlling whereas the other was indulgent. You learned to follow your impulses and to resist authority. You tend to see the world as a “dog eat dog” place, so it is important for you to be “top dog” and not let anyone have control or authority over you. Because you thought you had to be manipulative to get your needs met, you have learned to manipulate others. Telling benign or more blatant lies and bending the rules is the way you think you can get ahead. You might actually see people who follow rules as weak or stupid. Some people with your profile often do very well in life for periods of time, but events often catch up with them. Some of the ways that things can go wrong may include getting into trouble with the law or authority figures, or taking too big a risk, leading to disastrous consequences. Whatever you enjoy, you’re likely to do intensely and without a great deal of discipline. Consequently, it is easy for you to become compulsive and even addicted. Talk to your therapist about your early childhood and explore whether you felt you had to be manipulative and devious in order to get your needs met. Learn to modulate your impulses so they do not get you into trouble. Pay more attention to the details of your life so that you’re not reckless. Whenever you are engaged in an activity that could get you into trouble, try to imagine what it would feel like to be caught and punished. Follow through on your commitments. Be mindful to not tell lies and manipulate others, as that is likely to lead to the loss of things in your life that you want to keep. Remember that your optimism and high energy can push you into impulsive and reckless acts that will occasionally backfire, with serious negative consequences.

Feedback Statements—Elevated Profiles (T-Score > 65)

Strengths

Your profile shows that you have a number of strengths. You are a highly energetic, independent, excitement-seeking, and adventurous individual. You think for yourself, you hate to be controlled, and you’re not afraid to blaze new trails. You’re the kind of individual who does best when you’re given a great deal of freedom and you’re allowed to be creative and follow your own impulses. People see you as exciting and fun to be around. You appear to have two gears: full-speed-ahead and off.

Difficulty Trusting

Although you have strengths, you also have vulnerabilities. People may see you as charming, friendly, and easygoing, but underneath you have difficulty trusting emotionally and allowing yourself to be vulnerable. You don't tell people your vulnerable feelings and don't let yourself rely on others for emotional support because you worry that if you reveal any weakness or vulnerability others will take advantage of you.

Manipulating

You see the world as a "dog-eat-dog" place where being in control, having power over others, and not letting people restrict your way of life. You have a tendency to be manipulative, to look for people's vulnerabilities, and to see how you can exploit them, finding ways to get what you want by influencing and intimidating them.

Charismatic or Self-Serving

Underneath your charm and charisma, you can be very self-serving, even narcissistic and callous. Although others are often charmed with your easygoing, joking banter, you don't allow yourself to form deep and caring relationships. You go through life taking what you want and doing what feels good without real regard for how others feel. In fact, people may accuse you of being insensitive and, once they get to know you, may see you as unreliable.

Impulsive, Reckless, Substance Abuse

Living in the moment, doing what feels good, and not caring about consequences can make you fun to be around for a while. However, your impulses can often get you into trouble, sometimes leading to reckless, dangerous, and even illegal behavior. People with your profile tend to indulge in alcohol, drugs, gambling, or impulsive sexuality. If you do use chemical agents, they may disinhibit you even more, leading to rash behavior and trouble with authority.

Numbing Out or Difficulty Learning From Experience

When things go wrong, you likely get sad and down; however, it's hard for you to feel guilty or to acknowledge the pain you have caused others. Because you learned at an early age to numb yourself when others are angry or hurt because of your actions, you may feel a strange sense of emptiness, and even disconnection, from what they are saying and feeling. Although you can feel remorse temporarily, it doesn't seem to affect your future behavior.

Rebellious or Problems With Authority

People with your profile can be very effective for short periods of time. Your ability to “think outside the box” and to question the established way of doing things may allow you to take big risks that sometimes pay off. However, your instinct to resist authority and your tendency to take shortcuts can lead to your plans getting easily derailed. If anyone gets in your way, confronts you, or tries to control you, you can express anger in impulsive and intense ways, which backfires when dealing with authority figures.

Irritable or Angry

Long-term relationships are going to be difficult for you. While people may find you attractive, so that “hooking up” with others is relatively easy, staying loyal to one person is difficult. You tend to get bored and restless easily, and if you feel in any way controlled or held accountable you can get irritable and angry.

Lifestyle and Background Feedback

People with your profile often grew up in environments where parents were controlling, uncaring, or occasionally permissive but without meeting your needs. From an early age, you learned to be a survivor, relying on your own emotional resources and not letting yourself turn to others for support. Perhaps one of your parents was manipulative or abusive, or perhaps, for other reasons, you learned not to trust emotionally. You may recall situations where you had to “numb yourself” to survive emotionally. You’ve learned to be manipulative, to selectively report, or to tell lies as a way of getting around others’ demands on you. Now you’re going through life looking for people’s weaknesses and vulnerabilities, finding ways to get your needs met by exploiting, controlling, or intimidating others.

Normal-Range Feedback (T-Score 50 to 65)

Your profile shows that you have a number of positive strengths. You are a person who enjoys the unconventional and the exciting. You are highly resilient, so that small setbacks, losses, or blows to your self-esteem do not seem to knock you off balance. People see you as generally positive, upbeat, happy, and easygoing. You are also a risk taker and are not afraid to bend the rules, to think for yourself and to make spontaneous and even impulsive decisions. People with your profile are independent, hate to be controlled, and enjoy living on the edge. Others generally see you as charming, freewheeling, and easygoing. Underneath your charm, it’s hard for you to trust, to let down your guard, and to allow people to get close. In fact, when you care about people, you tend to worry about losing them, and you might even become a little jealous and possessive. People with your profile can be impulsive, sometimes jumping into things before they have fully thought through the consequences. At times your inattention to detail and

your tendency to postpone things until you really need to get them done can get you into trouble.

(Levak, Siegel, Nichols, & Stolberg, 2011)

493/943 Codes

The addition of Scale 3 predicts needs for emotional closeness and approval, which results in a veneer of superficial niceness and role-playing social conventions. Typical 49/94 acting out will be muted, with anger expressed in disguised, perhaps in joking and sarcastic ways, or passive-aggressively. The interaction of these scales suggests individuals who have conflicts between their need for approval and acceptance from others, and at the same time, their need for autonomy. If Scale 3 is within five *T*-score points of Scale 4, then many of the characteristics of the 34/43 codetype may also be present. An elevated *O-H* scale would suggest a buildup of anger due to denial, with occasional explosive outbursts, usually directed at a family member. If the *O-H* scale is not elevated, then explosive episodes are less likely, with anger expressed as more impulsive irritability associated with 49/94 elevations. In general, the 493/943 codetype reflects individuals who have a high need for approval, success, and power, and they are willing to play manipulative social roles, and justify bending the rules in order to get their needs met.

TREATMENT

Look for early childhood experiences of rejecting, discounting, controlling parents who had a strong need for the child to succeed. Parents who themselves played correct social roles, but acted out subtly, may have modeled acting out as a way to get ahead. Helping these individuals to recognize when anger is accumulating so they can express it directly, rather than in passive-aggressive or explosive ways, can be useful. The therapist can benefit from acting as a “coach” to the individual, validating their needs for success and approval, and helping them to identify ways to be successful without needing to manipulate others or act impulsively. These individuals are often unaware that they are role-players and manipulators, assuming or projecting that others behave as they do. The therapist should help them distinguish between their own needs versus their internalized caregiver’s expectations. Help them process their conflict between needs for approval and needs for autonomy. The therapist’s limit-setting needs to be mixed with approval to keep the individual involved.

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you are a driven, energetic, ambitious individual. You have a strong need for approval and success, and you care about what people think of you. However, you also have a strong need to be independent and dislike being controlled. In some ways, these traits are contradictory. The way you resolve them is by playing the right role in front of people whose approval you want, following the rules on the surface, and using your social skills

to charm people, but then carefully doing what you want and bending the rules to fulfill your needs. In some ways, you can live a double life: the conformist, rule-following, nice individual, and yet somebody who can bend the rules and be subtly manipulative. You dislike hurting anyone's feelings or rejecting them, so you may express anger in roundabout, subtle ways. Perhaps you express irritation with a sarcastic, joking humor. In other cases, people with your profile do not even realize they are getting angry until they have accumulated a number of resentments and occasionally, though infrequently, explode. After you've become angry, you may feel some relief, but you might not realize how others have been negatively affected by your angry episode. In many cases, people with your profile grew up with parents who were demanding and who could be controlling, discounting, and rejecting. Perhaps from an early age you learned that playing the right role was how one got along. You may also have learned that being manipulative and getting around the rules was more effective than being direct and asking for what you wanted. Work with your therapist to recognize when anger is building. Learn to express what you want directly, and be mindful to not express your feelings in joking or sarcastic ways. Identify what you really want in life versus what you feel others expect you to do. You may have some conflict between your need for independence and your need for others' approval. Be careful not to overpromise because of your fears of rejecting others. Avoid telling white lies as a way of getting what you want, because people who care about you will eventually lose trust in what you tell them.

495/945 Codes

(see also 49/94 Codes and Spike 5)

Elevations on Scale 5 in men moderate the aggressive acting out that is associated with Scales 4 and 9. High 5 males are aesthetically oriented, care about feelings, and are often educated and intellectually curious. The 49 high 5 male may be an intellectual rebel, espousing nonconformist causes, and may act out sexually, but not be antisocial. The addition of Scale 5 to the 49 codetype reflects sensitivity and aesthetic, intellectual values that others experience as self-centered and self-absorbed.

TREATMENT

Men with 495/945 codetypes tend to be more interested and responsive to psychotherapy than the 49 individual. Intellectually curious, verbal, and insightful, they are more amenable to being "coached," especially by a warm, approving psychotherapist who sets non-authoritarian, good-natured limits. Look for childhood conditioning experiences similar to the 49/94 codetype.

49 high 5 women, on the other hand, tend to be assertive, surgent, demanding, and often highly sexual. The elevation of Scale 5 predicts a practical, action-oriented female, and increases the likelihood of assertive, and even

aggressive, acting-out behavior. Women with this codetype would look for practical advice rather than insight therapy.

THERAPEUTIC FEEDBACK LANGUAGE

See 49/94 codes for feedback.

496/946 Codes

The addition of Scale 6 to the 49/94 codetype predicts suspiciousness, paranoid sensitivity, and vindictiveness. Scale 6 acts as an “organizer” for the more impulsive, hedonistic live-in-the-moment qualities of the 49 individual. President Richard Nixon may have exhibited some of the qualities associated with a 496 profile. His tenacious drive, keeping of an “enemies” list, and episodes of paranoia capture the essential qualities of this codetype. These individuals are very sensitive to any slights, criticisms, or demands made on them. Some, when threatened, can be assaultive, especially if they feel they have been somehow wronged or treated with disrespect. All 496/946 individuals have a tendency to store resentments and be unforgiving and manipulatively vindictive, but not all are physically dangerous to others. They can pursue vengeance with a determination that is lacking in the pure 49/94 live-in-the-moment individual. When anger is expressed, it comes out as a dangerous breakdown of brittle control. If Scale 8 is also elevated, then episodes of bizarre violence would not be unusual. Some individuals may show brief psychotic episodes, and others can become more openly schizophrenic over time. Childhood histories often reveal arbitrary, controlling, and severely critical caregivers who may have been strict, using physical punishment and shaming as a way of controlling the child. Consequently, these individuals show a strong response to any attempts to control them, and are quick to feel criticized. They tend to have a “chip on the shoulder” attitude in life, ready to argue or fight for a cause. Educated individuals with a 496/946 codetype are argumentative, rationalizing, externalizing, and blaming, but these behaviors are expressed verbally. People with less ego strength are more prone to act out violently and impulsively when threatened.

With this profile, explosive outbursts of aggression may occur, especially if 8 is also elevated (Carson 1969).

TREATMENT

See also 49/94 codes. Anger management and impulse control strategies are most useful. Help these individuals understand how their quickness to argue and defend themselves and their tendency to obstinately “argue their position” makes adaptive sense given their childhood experiences of having been shamed and treated unfairly by authoritarian caretakers. Help them recognize how and why opinionated people can now engage them into

becoming reactively argumentative. In the presence of psychosis, medication is required, although their paranoid sensitivity to being controlled would need to be managed before medication is suggested.

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you are going through life on edge, as if anticipating being controlled, criticized, judged, or having unfair demands made on you. People with your profile often grew up with a parent who was controlling and unfairly punishing, or perhaps used shame to discipline. That may be why you learned to be wary of anybody trying to control or make demands on you. Currently, you appear to be feeling vulnerable to being criticized, judged, or attacked. You may fantasize about ways to protect yourself and retaliate against people you feel have hurt you. Sometimes your sensitivity to criticism and judgment may actually shade toward paranoia, and it is hard for you to know whom you can trust. When people hurt you, it is hard for you to forgive them, perhaps because you've experienced painful and unfairly inflicted wounds in the past. Others may sometimes see you as a little prickly, ready to argue and feel hurt, and sensitive to any demands being placed on you. It is as if you want others to prove that they are trustworthy before you let down your guard. Authority figures tend to make you want to resist them, and others may see you as stubborn about doing things your own way. Work with your therapist to identify childhood events where you felt unfairly judged, criticized, shamed or punished. Work on learning to ask for what you want before you feel resentful and come across as demanding. Be mindful that you may be too quick to feel hurt and angry, and that punishing people for hurting you can make them defensive and argumentative. Become aware that you are going through life overly vigilant, as if you are about to be attacked or have something taken away from you. It leads you to be defensive and argumentative in a way that makes people want to argue with you and resist your requests.

498/948 Codes

(see also 489/849 Codes)

In addition to the 49/94 features, the likelihood of strange, unusual, bizarre, and/or violent behavior is high. This codetype usually represents major and enduring psychopathology. In adolescents, this codetype can be associated with situational difficulties, such as an identity crisis and adolescent rebellion, rather than the personality disorder found in adults. Nevertheless, both adults and adolescents experience intense feelings of alienation from others, family conflicts, high energy levels, difficulties with authority, and rebellious behaviors. They particularly fear feeling vulnerable and, in conversations, they are likely to jump from topic to topic to avoid talking about emotionally vulnerable issues. They can be charismatic but also bizarre, and converse casually about sexuality

and aggression.

498/489/849/894/948/984

o Like 4-6-9 but less organized and more charismatic, grandiose, exploitive, unstable, and chronically hostile. May be menacing, predatory, and sadistic. Severe disidentification with authority; empathy defects; may be cold, extremely manipulative, ruthless, and prone to violence. Unusual or bizarre dress and grooming may be used to attract attention or to keep others at an emotional or physical distance. May be psychotic and disorganized. Look for history of underachievement and poor socialization if not brutalization; criminality, assault, and substance abuse. Check:

AGGR, RC9. See 4-8/8-4, 4-9/9-4, 8-9/9-8.

TREATMENT

See treatment section under the 489/849 codes.

40/04 Codes

This codetype predicts an individual who is alienated, distrustful, dysphoric, and lacking in empathy. They see the world as a “dog eat dog” place from which they have self-protectively withdrawn. They have difficulty expressing vulnerable emotions in a modulated way. Anger, frustration, and even attempts at intimacy can be expressed in an abrupt, interpersonally clumsy fashion. Others see them as aloof and may describe them as cold and unfeeling. They feel alienated from people and experience low self-esteem. These individuals typically act out within the family rather than resisting authority or acting in antisocial ways. They tend to be loners and have difficulty with emotional closeness and intimacy, yet are unlikely to express much psychological distress except for dysphoria and self-deprecation. They have habituated to living an isolated, emotionally self-sufficient, though alienated life.

Adolescents in treatment with the 4-0/0-4 pattern (Marks et al., 1974) were suspicious and distrustful. They were resentful and prone to acting out. They were also shy and had few friends. The Marks, Seeman and Haller book should be consulted for further information concerning this pattern.

o Dysphoric, alienated, avoidant, thin-skinned, resentful, and suspicious. Social timidity. Conflict with family. Substance abuse.

Check third highest scale. Check *Dr5, Pa1, Sc1, INTR*.

TREATMENT

These individuals rarely seek treatment. Therapeutic contact will likely be made due to relationship problems, dysphoria, chemical addiction, or work problems. Childhood histories of caregivers who were emotionally distant and uninvolved are typical. The high 40/04 individual has learned to be emotionally self-sufficient, perhaps as a defense against early parental withdrawal or lack of emotional availability. They have learned the role of a self-sufficient loner, and they appear to need little social interaction or validation. Practical information and advice about how others feel and interpret their behavior could be helpful. One 40 patient was discovered to have been involved with prostitutes by his distraught wife. He was angry that his apology was not enough for her to drop the matter, and that she insisted he seek therapy to understand the reasons for his infidelity. He was genuinely puzzled why an apology did not assuage her. Teaching 40/04 individuals how others feel and how to respond to loved ones can be useful. Determine how much of their self-sufficient withdrawal is constitutional and how much is a response to parental neglect in order to develop a therapeutic strategy. Using cognitive behavioral techniques to teach them how to express anger, tenderness, love, and frustration can be useful. Self-esteem building and social skill exercises can also be useful.

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you are a self-sufficient, independent individual. You are shy, and find small talk and social events where you do not know people to be difficult and unpleasant. You have learned to be a survivor and to rely on your own emotional resources. In times of stress, you rarely turn to others or ask for emotional support. You see the world as a place where people do not really care for one another and where relationships are often more bother than reward. Others may see you as a little cynical, abrupt, and aloof. People may misjudge you as a snob because you do not make an effort to reach out to others. Perhaps you have always been somewhat shy and, growing up, you learned to be self-sufficient because your parents were emotionally unavailable. Now it is hard for you to connect with others emotionally, let down your guard, and feel emotionally vulnerable. You tend to be quite self-critical and, although you do not experience a great deal of joy from life, it is hard for you to feel that opening up and talking to a therapist would do much good. Work with your therapist to understand how to deal with your shyness. Learn how to recognize what other people are feeling and remember that others often need more emotional connection and support than you do. If you are involved in a relationship, learn how to talk about emotional experiences so that your partner feels a sense of connection with you.

Scale 5: Masculinity–Femininity (mf) Males: T-Score Above 65

Descriptors

Complaints

Passivity, possible sexual problems, nonaggressive, strong needs for attention, possible relationship concerns

Thoughts

Artistic, philosophical, aesthetic, perceptive, insightful, idealistic, curious, tolerant

Emotions

Peaceable, sensitive, prone to worry, caring, empathic, tender, nurturing, non-confrontational

Traits and Behaviors

Passive, sensitive, conflict avoiding, intellectual, cultural/verbal/aesthetic interests, submissive, stereotypically feminine interests, may have sexual identity issues

(Levak, Siegel, Nichols, & Stolberg, 2011)

Therapist's Notes

Scale 5, originally constructed to identify homosexuality (Hathaway, 1956), works more as a measure of gender identity than of sexual preference. Scale 5 was originally conceptualized as a bipolar dimension, although current thinking is that masculinity and femininity are independent dimensions (Gonen & Lansky, 1968; Sines, 1977).

Men scoring above a T-score of 65 on Scale 5 are described in generally positive terms. In the absence of elevations on other clinical scales, they are lacking in aggressive and self-serving impulses and tend to be nurturing; interpersonally aware; culturally, verbally, and aesthetically oriented; and concerned with the state of their interpersonal relationships. They can also be fussy and passive, needy of attention and affection, and lacking in assertiveness.

Scale 5, in the feminine direction, acts as a modifying variable when elevated with other clinical scales. For example, when Scale 5 is elevated in a 4-9 profile, the acting out associated with the code type is likely to be expressed in more intellectual, interpersonal, and sexual rather than directly aggressive ways.

As Scale 5 elevates above a T-score of 65 for males, it suggests increasing passivity, sensitivity to rejection and insecurity, and preoccupation with relationships. Men with this profile are creative and interested in philosophical and psychological issues. High 5 males tend to be quite perceptive and responsive to interpersonal nuances. They are comfortable communicating their feelings and tend to be tolerant of others. The downside is that they can be ruminative, self-doubting, and self-effacing.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Lifestyle and Family Background

Our hypothesis is that Scale 5 has a genetic component that is expressed and shaped by the strength of the child–mother or mother–surrogate relationship. High 5 males tend to be involved in occupations that value interpersonal awareness, sensitivity, and the ability to nurture others. They are drawn to cultural, aesthetic, and verbal pursuits such as theater, the arts, teaching, and fashion. As children, anecdotal evidence suggests they are nonaggressive, dislike the rough and tumble of surgent masculine activities, and exhibit intellectual curiosity. At the same time they can be quite athletically competitive. They relate exceptionally well to women and are often concerned about their own appearance.

(Levak, Siegel, Nichols, & Stolberg, 2011)

A high score ($T \geq 65$) and Spike 5 codetype in a man suggests an introspective, inner-directed, and education-oriented individual who has a wide range of interests, including aesthetic and contemplative preferences. Often these men are seen as idealistic and imaginative, socially perceptive, and interpersonally sensitive. They are interested in intellectual activities, have a humanistic perspective, and value appearance, style, and intimacy. In individuals with high educational and cultural backgrounds, some of these characteristics are modal. However, this pattern may reflect a discomfort with stereotypic masculine behaviors, activities, and interests in favor of a more non-competitive, contemplative, and, at times, passive style. Because Scale 5 in men is strongly correlated with education, intelligence, and cultural breadth, high elevations should not be interpreted as pathological. In fact, adjectives used to describe high 5 men tend to be positive. Others describe them as mature, self-controlled, insightful, and self-aware. This scale tends to be at least moderately elevated for well-adjusted members of various occupational groups,

such as social scientists, writers, artists, ministers, teachers, and psychologists. High scorers, with no other scales elevated, can sometimes be described as passive, particularly if Scale 9 and 4 are low, and some may exhibit mannerisms that are seen as traditionally feminine. Elevation of Scale 5 is never sufficient to suggest homosexuality, either overt or latent. Homosexuals who wish to conceal their orientation on the MMPI-2 can readily do so. That said, when Scale 5 is above *T*-75 score, a male likely rejects the traditional masculine lifestyle.

- Neuroticism, passivity, introspectiveness, perceptiveness, dependency, low self-confidence, oversensitivity, disrupted thinking, mild suspiciousness, and low masculine identification in men. Check *Mf* subscales and *GM* – *GF*.

Description:

- Either transient situational disturbance or normal, liberal college males and open homosexuals, rep. self-confidence and good physical and psychological health

Modifying Scales

- Elevation on Gender Masculine (GM) and Gender Feminine (GF) enhance the interpretation of high Scale 5 elevations. If GM is elevated and GF is normal or below 50, these males may well exhibit positive features such as self-confidence, freedom from fears and anxieties, and an attractive balance of sensitivity, creativity, and practical self-sufficiency. Descriptions of such a male conform to the popularized concept of a “metrosexual.”
 - On the other hand, a normal or low GM score, together with a high GF score, would predict an accentuation of the passivity and fussiness associated with high Scale 5 scores.
 - Scale 5 mutes the aggression associated with Scales 4 and 9, increases the passivity of Scales 2, 3, and 7, and increases the introspection and sensitivity of Scales 6 and 7.
- (Levak, Siegel, Nichols, & Stolberg, 2011)

Male

Low 0 This pattern was infrequently associated with introversion or self-consciousness or social insecurity, lack of skills with the opposite sex, being nonresponsive or nonverbal, tension.

Low 1 Restless.

Nothing Low Home conflict, insomnia.

(Drake & Oetting, 1959)

TREATMENT

Men in the high scoring range and women in the normal and low scoring range tend to be feeling-oriented, so they have an affinity for psychotherapy. They are curious about themselves and their loved ones, and enjoy the process of gaining insight. Men and women scoring in the masculine direction on Scale 5, on the other hand, tend to approach therapy looking for practical advice and feel uncomfortable with the analysis, labelling, and processing of feelings. They are looking for advice on what they need to do to solve interpersonal problems.

Males with high 5 scores and no other scales elevated generally are described in positive terms, but they may experience relationship or sexual problems because of their sensitivity and self-consciousness. They may be somewhat passive, giving in to others' expectations. In the work situation, they have difficulty asserting themselves, especially in positions of power. They tend to be democratic in their management style and they feel overwhelmed by having to be tough with others.

Therapy and Therapeutic Pitfalls

As elevations on Scale 5 are associated with interpersonal sensitivity, verbal fluency, and perceptiveness, these clients are usually good candidates for therapy. Generally curious and psychologically aware, they respond well to insight and analytic therapies. At the same time, some may avoid behavioral change without some pressure, due to their passivity and self-doubt. Gestalt therapies, which require an emotional response without the control of the observing ego, tend to be helpful. Insight therapy can also be used effectively. In some cases, explore possible childhood teasing or bullying. Assertiveness training and exploring self-acceptance as a sensitive male, can also be useful. In the presence of any gender identity or sexual preference problems, therapy should focus on helping individuals come to terms with their sexuality. Scale 5 elevations are generally associated with positive therapeutic outcomes.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Treatment and Self-Help Suggestions

1. Discuss with your therapist whether your rejection of the stereotyped male role caused you pain as a child.
2. Resilience building: Learn to identify what it is you want from people, and ask for it rather than wait for others to initiate. Work on being more assertive, especially when someone hurts your feelings. Practice assertive requests with your therapist: role play situations where it is difficult for you to make requests. Assertive statements begin with "I" (e.g., I want; I feel; I think), "When you" (e.g., make jokes; don't help with housework; have me work late hours), and "I would appreciate it if you would in the future" (e.g., not

make jokes at my expense; do the dishes every other night; give me advance warning when you want me to work late).

3. Accept your high level of sensitivity, and appreciate that it may help you with your creativity and interpersonal skills. Studies have linked aesthetic sensitivity in children to artistic potential, independence, learning potential, and achievement.¹
4. In your close relationships, be aware when you are overlooking your own needs in order to keep the peace or to take care of others. A good Web site for information on codependency is

<http://www.nmha.org/go/codependency>.

(Levak, Siegel, Nichols, & Stolberg, 2011)

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you are a sensitive, artistically oriented man who rejects traditional stereotypic masculine interests and values. You care about peoples' feelings and are comfortable in a creative world. You might find the competitive male world less interesting in favor of a more intellectual and cooperative environment. At times, you may be passive, hanging back from expressing what you want in order to not be seen as controlling or pushy.

Feedback Statements—Elevated Profiles (T-Score > 65)

Strengths

Men with your profile have a number of strengths. You are interpersonally aware, perceptive, and sensitive to how others feel. You care about your relationships, and you go the extra mile to look after and support the people you care about.

Aesthetic

You may enjoy art, literature, clothes, fashion, jewelry, and interior decoration. Generally, you are seen as “choosy,” caring about your overall appearance. How things feel and look are as important to you as how they work. You spend energy to make sure your living environment is attractive and aesthetically pleasing. Others may see you as somewhat fussy and demanding because of your attention to the details of how things look.

Passive or Nonaggressive

You are generally nonaggressive and value your ability to express yourself verbally. Men with your profile are generally good with words and, when angered, can be sarcastic or verbally cutting as a way of expressing anger.

Others may see you as rather passive; you may not always express what you want and tend to wait for others to make the first move. Having people around you agree and be in harmony is important to you.

Nonassertive or Peaceable

Men with your profile have a wide range of interests and tend to value cooperation and interpersonal relationships.

Your tendency to be idealistic and peaceable may, at times, mean that you are nonassertive. You may find yourself shrinking from disagreement and not always telling others exactly what you want and how you feel, in order to get along with everybody.

Lifestyle and Background Feedback

You have likely always been sensitive, gentle, and uncomfortable with conflict. Perhaps as a child you were close to a parent figure who found your sensitivity and lack of aggressiveness pleasing. In some cases, boys who reject traditional masculine interests and activities are teased and humiliated by their peers. Being around rough, insensitive boys may have been difficult for you, especially if you were not good at traditional masculine sports and activities. You may have found a way to be accepted by your peers in sports or other competitive pursuits, which allowed you to develop a healthy balance between your male and your female sides.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Low 5 Male

Males: T-Score Below 45

Descriptors

Complaints

Practical, lacking in insight, few complaints, interpersonal problems due to a lack of emotional awareness

Thoughts

Practical, action oriented, uninterested in deep psychological insight and self-awareness, not preoccupied with effect on others, practical interests, unaffected, adventurous

Emotions

Unexpressive, self-contained, self-confident

Traits and Behaviors

Independent, practical, down-to-earth, no-nonsense, adventurous, outdoor interests, action oriented, masculine interests, direct, uncomplicated, may project an “all-male” image

(Levak, Siegel, Nichols, & Stolberg, 2011)

Therapist's Notes

Men low on Scale 5 are action oriented, practical, adventurous, and independent and generally lack psychological insight, possibly due to disinterest. They are people who tend toward action when stressed rather than contemplation or self-examination. They find introspection and deep analysis of feelings to be uninteresting unless it has immediate practical application. These men identify with masculine values and traditional masculine roles. Their lack of introspection and self-doubt generally leads to self-confidence and positive self-esteem. Their range of interests tends to be narrow, and some men project an “all-male,” “John Wayne” image. In some cases, this is a combination of cultural and temperamental characteristics, but in rare instances it can include a defensive exaggeration of masculine strength.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Lifestyle and Background Feedback

Low Scale 5 in males reflects a combination of temperament and background. In some situations, these individuals had a strong identification with a father figure and were rewarded for being practical, independent, and action oriented. They developed a logical, practical orientation to emotional interactions. Conceptually, men with this profile, especially those with an elevated Scale 0, are the type to construct a log cabin in the mountains, to sail a boat single-handedly, or to work on mechanical and engineering projects in hazardous or isolated places. They are comfortable in the armed forces, police, or firefighting services where they can be practically helpful to others. (Levak, Siegel, Nichols, & Stolberg, 2011)

If Scale 5 is elevated in males, and the *GM* scale is also elevated, a healthy androgyny is also suggested. Moderately low scores ($T=35-45$) are interpreted differently for men and women. Low Scale 5 men show a traditionally masculine pattern of interests and behaviors. They are adventurous and enjoy action, outdoor activities, sports, and competitive or mechanical activities. They often appear rugged and can appear coarse. If educated, they gravitate toward practical, action-oriented careers rather than careers that involve nurturing or coaching others.

When Scale 5 is very low ($T \leq 35$), men espouse a very practical, action-oriented lifestyle and enjoy traditional masculine activities and pursuits. They have difficulty communicating feelings and are uncomfortable with discussions about emotions. When interpersonal problems arise, they want to “do something about it” rather than talk about it.

Modifying Scales

- Low Scale 5 in males acts as an energizer. Moderate elevations on Scales 4 or 9 (e.g., T-score 60) would enhance the likelihood of assertive and even aggressive behavior.
- When Scale 0 is elevated and Scale 5 is low, these individuals are likely to be self-sufficient and perhaps loners.
- An elevated Aggressiveness (AGGR) would predict assertive acting out. If Anger (ANG) is elevated, it may be expressed in a direct, even physical, manner.
- When Type A Behavior (TPA) is elevated, they can be irritable, impatient, driven, and competitive in a loud and possibly hostile manner.
- Elevations on Inability to Disclose (TRT1) would confirm difficulty with introspective psychotherapy.

(Levak, Siegel, Nichols, & Stolberg, 2011)

TREATMENT

Therapy and Therapeutic Pitfalls

When these individuals seek counseling, it's usually for practical advice about how to solve immediate difficulties. Therapy should focus on practical, action-oriented, problem solving. In the absence of any clinical scale elevations, coaching about how to read and respond to other people's feelings and teaching empathy can be productive. Help them understand that silence in the face of others' emotional pain tends to be received negatively, and discuss with them learn that support does not have to mean solving a problem. These clients can be uncomfortable with therapists who are emotive and physically expressive or who use psychological jargon. The language of emotions can appear alien, even frightening, so it should be introduced gradually and in the context of practical "how-to" information. It can be helpful for a therapist to develop a "male bond" around practical masculine activities such as occasional small talk about sports, projects, or current events. In marital therapy, therapists should be mindful that it can be threatening to a practical, nonemotive individual to observe his partner expressing emotions with a fluent, empathic therapist.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Treatment and Self-Help Suggestions

1. There is nothing "wrong" with having strong masculine values, interests, and identification. Others, however, may become impatient and angry with you because you appear not to "share your feelings" enough. Some people may require more emotional expression from you to feel close. This is something you and your therapist could work on together.
2. Talk to your therapist about ways to "read" other people's emotions. If people appear sad, distant, or angry, don't be afraid to ask how they are feeling to gain a better sense of empathy for them. Learning these skills can improve both personal and professional relationships; a major difference between outstanding and average leaders is linked to "emotional intelligence." Find out more about these essential people skills in Daniel Goleman's (1998) book *Working With Emotional Intelligence*.

(Levak, Siegel, Nichols, & Stolberg, 2011)

THERAPEUTIC FEEDBACK LANGUAGE

Feedback Statements (T-Score < 45)

Your profile shows that you are a “man’s man.” You have traditional interests and values, and you enjoy practical, physical, adventurous, outdoor activities.

Independent or Action Oriented

You are independent and self-sufficient, and you tend to move into action when stressed. Some people need to talk about how they feel, expressing their vulnerabilities to others, perhaps organizing their emotions by “feeling” out loud, but you look for practical solutions and immerse yourself in activities as a way to deal with inner turmoil.

Complaints by Loved Ones About Lack of Emotional Response

Interpersonal relationships can be complex for you if they demand an emotional response. You may find it tedious or even boring to think about your feelings or to explore how another person is feeling. Typically, if a difficult situation arises between you and someone you care about, you try to get past it, perhaps distracting yourself with problem-solving. When it comes to emotions, you may find yourself at a loss for words and unable to label what you are feeling. It’s not that you’re withholding your emotions from others purposefully; it’s just that you don’t operate in an emotional way.

Traditional Masculine Interests

Action-oriented and mechanical, perhaps outdoorsy, you enjoy traditional masculine activities and pastimes. You may have conventional values when it comes to men’s and women’s roles. Hunting, fishing, sports, mechanical activities, cars, and adventure movies tend to be interesting to you. Because you are so practical, how things function tends to be more important to you than how things look. For you, actions speak louder than words.

Lifestyle and Background Feedback

You have likely always been someone who has strong masculine values and traits. As a boy, you were probably an action-oriented, independent person who liked sports and outdoor activities. Perhaps you had a strong relationship with a male figure, or your mother valued and enjoyed you being “her little man.”

(Levak, Siegel, Nichols, & Stolberg, 2011)

Spike 5 [Female]

Females: T-Score Above 60

Descriptors

Complaints

Uncomfortable with traditional feminine role; may be seen as assertive, controlling, or loud; competitive; generally few complaints

Thoughts

Practical, competitive, narrow range of interests, sensible, logical

Emotions

Unemotional, self-confident, assertive, willful

Traits and Behaviors

Resilient, logical, rational, sensible, self-assured, adventurous, outdoors oriented, practical, can be loud and assertive, competitive, achievement and career oriented

(Levak, Siegel, Nichols, & Stolberg, 2011)

Therapist's Notes

Our hypothesis is that high Scale 5 scores in females reflect temperament and sociocultural influences. Typically, as children, these women rejected stereotypical feminine traits and values and may have identified themselves as “tomboys.” They enjoyed outdoor activities, were competitive, liked to climb trees and play with boys, and generally did not play with dolls. These types of women can be adventurous, self-sufficient individuals, who are comfortable traveling alone, starting their own business, and tend not to take things personally. At times, they can be seen as somewhat coarse, especially if uneducated; more traditional females might see their blunt, direct, no-nonsense expression of emotions as lacking in polish. Competitive and career oriented, they are sensitive to being defined by their gender. Nevertheless, they can exhibit grace and refinement.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Lifestyle and Family Background

Identification with a male parent and the encouragement of action-oriented, outdoor self-sufficiency in the presence of a genetic predisposition is suggested. Early interests in sports, the outdoors, and comfort with male friends is typical.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Women who obtain an elevated Scale 5 above T -65 can be described as assertive, competitive, tough-minded, sensible, practical, and not particularly interested in appearing or behaving in a traditional feminine manner. Others describe them as independent, self-confident, spontaneous, dominant, and even aggressive in the pursuit of their goals. They are seen as tough-minded at times, coarse, and are comfortable in the presence of men. This may be expressed in pragmatic career and/or survival behaviors, or in traditionally masculine sports or interests.

Interestingly, the mean Mf scores for women applicants to the reality TV survival competition, *Survivor*, is a T -score of 60. It makes intuitive sense that women who are willing to live with no resources and compete with men over six weeks on an island would be practical, competitive, and tough-minded (Richard Levak, August 4, 2007, personal communication).

If no other scales are elevated, Scale 5 elevations in women can predict positive qualities associated with independence, self-reliance, and assertiveness. If GF is also elevated, the elevation on Scale 5 in women can suggest a healthy, balanced androgyny.

o Better adjusted than patients in general but with conflicts around aggression. Social aggression, self-confidence, decisiveness, insensitivity, competitiveness, narcissism, and low feminine identification in women.

Modifying Scales

- When Gender Role–Feminine (GF) is at T -score 50 or slightly above and Gender Role–Masculine (GM) is also elevated, the high Scale 5 (Mf) score could predict a woman who is well balanced between her masculine and feminine sides.
- In the presence of low GF , look for stronger male identification and rejection of stereotypic feminine roles and values.
- An elevated Scale 4 predicts more aggressive and sexual acting-out behavior. This is especially true if Scales 8 and 9 are also elevated. If Antisocial Practices (ASP) is also elevated, this potentiates the likelihood of aggressive acting-out behavior.
- When Scales 6 or 9 are elevated, look for more intense, competitive, angry, and explosive behavior.

- When Cynicism (CYN) is elevated in the absence of any other elevations except Mf, look for somewhat coarse, blunt, and pushy individuals.
 - When Type A Behavior (TPA) is elevated, Mf elevations would increase the competitive pushiness already associated with elevations on this content scale and may also be associated with increased irritability.
 - Mild 4-9 elevations (T-score of 55 to 60) in the presence of high Mf would suggest highly competent, uninhibited, adventurous, self-sufficient individuals.
- (Levak, Siegel, Nichols, & Stolberg, 2011)

Female

Low 0 Socially extroverted.

Nothing Low Distractible in study.

(Drake & Oetting, 1959)

TREATMENT

Therapy and Therapeutic Pitfalls

These clients want to be seen as competent and self-reliant. Generally, they would have few complaints and concerns except those associated with their drive for success, achievement, and independence. In some cases, relationship problems occur because they see their partner as lacking in drive and emotional resilience.

Treatment and Self-Help Suggestions

1. Sometimes women with your profile become involved in relationships where their mate does not appreciate their practical independence and self-sufficiency. Perhaps you feel somewhat controlled or misunderstood. It is important to understand your own needs and to negotiate them with your partner.
2. Be aware that your direct, no-nonsense style can sometimes come across as brusque, unemotional, and even insensitive.
3. Remember that other people can experience hurt feelings and need to spend time processing them. Discuss with your therapist how respectful treatment of others, mediation, and conciliation have all been established as key components of effective leadership and are equally important in personal relationships. An excellent book on the topic is *Primal Leadership: Learning to Lead With Emotional Intelligence* (Goleman, Boyatzis, & McKee, 2002).

4. You may experience some conflict between your need for independence and success and your need to fulfill some traditional feminine roles. Should you have any conflicts of this kind, it will be helpful to discuss them with your therapist.

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you find the world of men interesting because you enjoy competitive, action-oriented activities and hobbies. You may find the traditional world of women less appealing. When people are upset, you want to talk about how to fix it rather than talking about feelings. You may be quite competitive, athletic and enjoy outdoor, action-oriented activities.

Feedback Statements (T-Score > 65) Strengths

Your profile suggests you are at ease engaging in activities that are perceived as traditionally male. You are comfortable in the world of men and enjoy males as close friends.

Practical, Sensible, Competitive

Women with your profile are often direct, sensible, practical, emotionally resilient, and enjoy competing with men. You may find the company of traditional women less interesting and stimulating than being around men. You are likely independent, competitive, and you do not let emotions get the better of you. Women with your profile tend to be “hands on,” driven, ambitious, and dislike being controlled.

Logical or Business Oriented

You may be involved in business or some kind of action-oriented activity where your comfort with being logical, practical, and sensible is well rewarded. When you are stressed, you tend to move into action and want practical advice about how to make things better. Spending time talking about your feelings is less rewarding to you than doing something to feel better.

Adventurous

You may enjoy adventure, even if it's somewhat risky, and you're not afraid to do things alone. You may value being physically strong and having the endurance to face life's difficulties head-on.

Lifestyle and Background Feedback

Typically, women with your profile were tomboys growing up and may have been more comfortable with boys as friends. You may have also been close to a father figure who valued how you were practical and down-to-earth and loved the outdoors. You tend to be resilient and bounce back from life's adversities.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Low 5 Females

Females: T-Score Below 45

Descriptors

Complaints

Passivity, concerns about relationships, romantic, traditional feminine values and interests, unassertive, noncompetitive

Thoughts

Insightful; caring; understanding; home, service, and family oriented

Emotions

Nurturing, considerate, empathic, sensitive, emotional, loyal

Traits and Behaviors

Identifies with the traditional feminine role, “hopeless romantic,” can be submissive, hypersensitive, long suffering, relationship oriented

(Levak, Siegel, Nichols, & Stolberg, 2011)

Therapist's Notes

Educated women with low Scale 5 are described as having intellectual curiosity, perceptiveness, and interests in interpersonal relationships (Graham & Tisdale, 1983). Low Scale 5 women have a strong identification with the traditional female role. Sometimes they shade toward passivity and even a masochistic loyalty to relationships that are exploitative. Low Scale 5 would inhibit the expression of overt aggression if Scales 4, 6, 9, or 8 are elevated.

The acting out suggested by the elevations on these scales would tend to be muted, to involve interpersonal relationships, and to be verbal rather than physical. Elevations on Scales 1, 2, and 3 would suggest an almost masochistic trend in relationship adjustment with self-deprecation and a tendency to be codependent.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Lifestyle and Family Background

Low Scale 5 in women reflects both temperament and cultural influences. These women often describe early childhoods where they loved playing house and playing with dolls, and from an early age they knew they wanted a

family. In some cases, their relationships with their fathers or mothers involved encouragement of traditional stereotypic feminine traits.

(Levak, Siegel, Nichols, & Stolberg, 2011)

In women, moderately low scores ($T=35-45$) suggest sensitivity and concern about relationships, intimacy, and processing feelings. These women are usually nurturing and supportive, although as T -scores go below 40 this may also be accompanied by passivity. Like their high 5 male counterparts, these women are fastidious, care about their appearance, and have interests that are intellectual, academic, or aesthetic. Some are attracted to sensitive men, with whom they enjoy communicating about emotions. Professional and college-educated women tend to obtain T -scores in the 40 to 50 range on Scale 5, reflecting a balance between practicality and aesthetics.

In women, very low scores ($T \leq 35$) reflect a woman who may be so concerned about avoiding conflict and hurting others' feelings that she becomes co-dependent or allows others to take advantage of her. Her nurturing style may make it difficult for her to relate sexually to more assertive males whose sexuality she may find too rough or lacking in intimacy and finesse.

Modifying Scales

- Elevations on Scales 2, 7, and Repression (R) in the presence of low Scale 5 would suggest the tendency toward passivity and self-sacrificing martyrdom.

- The presence of Scales 4, 8, 9, Antisocial Practices (ASP), and Authority Problems (Pd2) would suggest passive-aggression, the storing of resentments, and acting out sexually and verbally rather than aggressively.

- When Gender Role–Masculine (GM) is elevated, the profile suggests a healthy balance between relationship interests and cultural aesthetic values on one hand and practical, action-oriented values on the other. If GM is low and Gender Role–Feminine (GF) is high, this indicates passivity, fussiness, hypersensitivity, and codependence.

- Self-sacrificing passivity would be suggested by elevations on Scales 1, 2, 7.

(Levak, Siegel, Nichols, & Stolberg, 2011)

TREATMENT

Therapy and Therapeutic Pitfalls

Therapists who are too direct and practical may appear coarse to these clients. Intellectually curious, oriented toward feelings, and disliking conflict, these individuals are suited to traditional insight and supportive therapies. Sensitive exploration of feelings rather than practical interventions is suggested.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Treatment and Self-Help Suggestions

1. Don't let yourself get into codependent relationships with others because you are so sensitive. Reading recommendations are *Codependent No More* (Beattie, 1992) and *Women Who Love Too Much* (Norwood, 2008).
 2. Learn to assert yourself if someone is pushing you around. Learn to say no without explaining yourself, and practice becoming more assertive. A good book on the topic is *When I Say No I Feel Guilty* (Smith, 1975).
 3. Take a class in some practical, action-oriented activity to learn more about your "male side." Here are a few ideas to get you started: try lessons in martial arts, self-defense, golf, or car maintenance geared to women (www.carcare4usgirls.com).
 4. Be careful not to romanticize your relationships, expecting someone to "sweep you off your feet." Practice ways of fulfilling your own emotional needs.
- (Levak, Siegel, Nichols, & Stolberg, 2011)

THERAPEUTIC FEEDBACK LANGUAGE

Feedback Statements (T-Score < 45)

Your profile suggests that you are a woman with traditional feminine values and interests. Family, home, friends, and relationships are very important to you.

Sensitive, Nurturing, Empathic

Dealing with feelings, hearing others' experiences, and expressing emotions is important to you. You are a sensitive person, and you have empathy for others. You may gravitate toward occupations in which your sensitivity and ability to take care of people are valued. Your kindness may lead others to take advantage of you.

Nonassertive or Noncompetitive

Because of your sensitivity and your empathy, you may have some difficulty asserting yourself, especially to people who are dominant and pushy. You can find it difficult to relate to people who are too assertive and who do not talk readily about their feelings. You are not competitive or aggressive and you value getting along with others rather than “winning” by taking advantage of people.

Lifestyle and Background Feedback

As a child, you likely enjoyed playing house and playing with dolls, and from an early age you knew you wanted a family. You may have been encouraged to be “polite” and “considerate” and were not apt to enjoy being competitive or aggressive.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Because of the special circumstances surrounding the derivation of scale 5 (see Chapters 1 and 6), a great many of the data from the Minnesota studies do not include material pertinent to scale 5. Thus, in the high-point-pair data summarized in Appendix M, the tabulations from Minnesota normal adults (Tables 1 and 2) and from the various patient populations omit scale 5. The effect of this enforced omission can be judged in part from the Iowa data provided in Tables 3 and 4 of Appendix M in which scale 5 has been included. The subjects in these latter groups are roughly comparable to the Minnesota normals. It can be seen that over 40 percent of these married men have scale 5 either as the peak score or as the second highest score in the profile. Were scale 5 to be ignored, these cases would be assigned to other cells, inflating the latter values correspondingly. On the other hand, the Iowa tabulations suggest that scale 5 is not a frequent peak score for normal female subjects; the Minnesota trends are probably not affected greatly by ignoring scale 5 in the high-point-pair data for females. It is interesting to note in the data from Hathaway and Monachesi (1963) in Tables 5 and 6 of Appendix M that the relative prominence of scale 5 in the profiles of ninthgrade boys and girls is reversed: more girls have scale 5 peaks than do boys at this age level. In the North Carolina college groups shown in Appendix M (Tables 7 and 8), the sex difference in the relative frequency of peaks on scale 5 is equally striking, while the prison groups (Tables 17, 18, 19, and 20) strongly resemble the adolescent population in the role played by scale 5. The college women with high scores on scale 5 in Black's tabulations were seen by their peers as indecisive, rebellious, natural, and unrealistic. The group was infrequently characterized by their peers as dreamy, poised, polished, or sensitive. In their self-descriptions, these girls saw themselves as rough, incoherent, shiftless, and unemotional. They omitted from their self-descriptions the terms popular, good-tempered, polished, peaceable, kind, lively, alert, sentimental, and emotional, and they did not claim to have wide interests or aesthetic interests. The various combinations of scale 5 with other clinical scales have not been extensively studied or reported. The importance of some of those patterns can be judged from the observations of Hathaway and Monachesi (1953, 1963) on the role of scale 5 (as well as scales 2 and 0) as an inhibitor of manifest delinquent

behavior. As an example, the combination 59 in the profiles of ninth-grade boys was associated with a delinquency rate of only 11 percent, as contrasted with an over-all rate of 22 percent for the whole sample of boys in the study. The characteristics inhibited by scale 5, however, may be quite different from those related to other inhibitors; scale 5 should not necessarily be considered as a suppressor of all undesirable forms of behavior.

Drake found that college counselees with a 59 pattern presented problems relating to a mother conflict when scale was coded low. He noted also that the 50 group showed introverted behavior, while in the group with a peak 5 and coded low such behavior, as might be expected, was conspicuously absent.

Dean and Richardson (1964, 1966) and Zucker and Manosevitz (1966) report data on the role of high 5 patterns in identifying personality inversion in homosexual male samples. They also provide data on additional two-point high-point code combinations.

Low-Point 5's

Black reported that the women in his college group with 5 as the low point in their profiles were described by their peers as worldly, popular, decisive, and versatile. They were not seen as energetic, undependable, shy, rough, unrealistic, or disorderly. In their self-descriptions the low 5 girls gave a less flattering picture of themselves: self-distrusting, self-dissatisfied, moody, polished, shy, sensitive, neurotic, unrealistic, talkative, sentimental, and having aesthetic interests were the descriptions they checked. They did not endorse balanced, independent, decisive, good-tempered, practical, relaxed, or modest. Although little definitive research has been directed to the occurrence and correlates of low 5 profiles in psychiatric groups, it should be noted that these patterns are common in women. It is observed clinically that the higher the elevation of the neurotic triad, the lower the value of scale 5 will be in this group. This configuration frequently accompanies a masochistic trend in the adjustive efforts of the woman, with self-depreciation, long-suffering sacrifice, and unnecessary assumption of burdens and responsibilities. The precise role of scale 5 in this configuration is poorly understood but specific difficulties in sexual adjustment appear frequently, especially when a low value of 5 is combined with at least moderate elevations on scales 4 and 6. (Dahlstrom, Welsh, & Dahlstrom, 1979)

5? Code

An elevation on the 5 scale for females can result from the omission of items (elevated ? scale), because a low raw score on scale 5 produces elevations on the women's profile.

53 Code

See also the 5-4 combination that follows.

1. If men have homosexual impulses and scales 5 and 3 are high, they tend not to have acted upon their sexual impulses but may only be thinking about them (Singer, 1970).

54 Code

See also the 5-3 combination above. the 4-5 combination, p. 149,

1. If men have homosexual impulses and scales 5 and 4 are high, they tend to be overt homosexuals (Singer, 1970).
2. Males with this combination may have a passive-aggressive personality.
3. This combination may be associated with male sexual delinquents of the more passive type.
4. The 5-4 combination is a common configuration for men who are nonconformists. They seem to delight in defying social conventions in their behavior and dress (Carson, 1969). Many male homosexuals who have this combination are proud of their unconventionality and tend to flaunt it.
5. Women who are rebelling against the female role tend to have this combination (Carson, 1969). Their behavior becomes more atypical with increasing elevation of the 4 scale (Carson, 1969).

(5)4 Code

(5 Scale T = 45 or Below)

1. Men with this combination tend to be flamboyantly masculine. In teenagers, this is often manifested in delinquent behavior (Carson, 1969).
2. Women with this combination may be hostile and angry, but they are unable to express these feelings directly. Therefore, they may provoke others to get angry at them. Then they can pity themselves, because they have been mistreated (Carson, 1969).
3. Women with this pattern may be passive-aggressive (Good & Brantner, 1974).

56/65 Codes

This is a rare codetype. In men, it suggests an insecure individual who fears emotional involvement with others. These men are fussy, sensitive individuals, whose feelings are easily hurt. They take things personally, and have difficulty expressing anger directly. At times, their sensitivity can shade toward paranoia, exhibiting unreasonable

jealousies and projections onto others. Others see them as somewhat passive, with a tendency to accumulate resentments and hurts. They also present as rational, intellectually-oriented, intensely loyal, somewhat aloof individuals, who need a great deal of reassurance. Anger tends to be expressed in brittle, judgmental ways, once they feel justified in expressing their hurts and resentments. They are sensitive to demands being placed on them. Many have high educational and career aspirations, and they tend to be interested in cultural, verbal, and aesthetic activities.

56/65 women, on the other hand, are usually more brash and direct. When hurt or angry, they can be judgmental and abrasive. They see the world in black and white terms and can quickly take offense, which they feel justified in confronting directly. They lack insight and see themselves as “right” and others as “wrong” in any confrontation, rather than understanding conflict as representing shades of grey. Further information can be obtained if a third scale is elevated above *T*-65 by temporarily disregarding Scale 5 and interpreting the other two scales as a two-point codetype (e.g. a 564/654 codetype can be interpreted as a 46/64 codetype with an elevated Scale 5).

o Aloof and guarded but with poor social skills and heterosexual adjustment. Socially awkward/uncomfortable. Irritable, abrasive, resentful, and impulsive. Look for history of absent father, unstable/ conflicted employment history, prior terminations or arrests, rigidity, intellectualization/hyperrationality, hypersensitivity, suspiciousness, overbearingness, fears of domination, impaired concentration. Rule out Schizophrenia. Check third highest scale. Check *Pa1*, *RC6*, *Pf1*, *Pf2*, *Pf3*, *Pf4*.

Adolescents in treatment with the 5-6/6-5 pattern (Marks et al., 1974) had more intellectual interests and valued wealth and material possessions more than other adolescents in treatment. They were irritable and acted out. They were sometimes suicidal and homicidal. The Marks, Seeman, and Haller book should be consulted for further information concerning this pattern.

Description:

Aloof, abrasive, self-righteous, see themselves as perfect

Male

Low 0 This pattern was infrequently associated with introversion or self-consciousness or social insecurity, lack of skills with the opposite sex, being nonresponsive or a nonrelator, tension.

Low 1 Restless.

Nothing Low Home conflict, insomnia.

Female

Low 0 Socially extroverted, resistant in the interview.

Low 2 Socially extroverted.

Low 4 Shy in the interview.

Nothing Low Restless, 8+ conferences, distractible in study.

- Note: Scale 5 coded high was infrequently associated with 8+ conferences.

(Drake & Oetting, 1959)

TREATMENT

Because these individuals are so sensitive to criticism or demands placed on them, look for childhood histories of a caregiver who was quick to criticize or judge, and/or quick to punish. Their interpersonal gestalt is one of protecting against criticism or judgment by being highly rational and justifying their behavior and perspective and, at the same time, needing to self-protectively judge others as “wrong” or “bad.” Help them find ways to express anger without judgment. Help them understand how their tendency to be judgmental was an adaptive response to unreasonably critical, shaming parents. Rehearse with them how to ask others to meet their needs directly, rather than waiting until they feel resentful or hurt before they express what they want.

THERAPEUTIC FEEDBACK LANGUAGE

For men: Your profile suggests that you are a sensitive, culturally, verbally, and aesthetically-oriented male. You value being rational, fair-minded, and analytical, and work hard to be above criticism. You have very high standards and analyze your feelings to make sure they are above reproach. At the same time, others may view you as hard to please, with a tendency to be critical or judgmental. Perhaps you grew up with a caretaker who was quick to criticize or judge, so from an early age you worked hard to be above judgment, internalizing your parents’ strong values. others may see you as a little quick to judge and slow to forgive. Because you are so sensitive, when people hurt you it takes a long time for you to forgive them. Work with your therapist on learning to recognize when you are storing up resentments, and learn to express your hurt and anger directly, without blaming. Ask for what you want without feeling you need to justify it. Sometimes people become argumentative if you ask for what you want by suggesting that others owe it to you. You may take things personally that were not meant to be a criticism. Remember that many people are less sensitive than you are, and can go through life unaware that other people are sensitive, so that they can be interpersonally clumsy but not necessarily “have it in for you.”

For women: (see feedback for Scale 5 and Scale 6 spikes): Your profile suggests that you are action-oriented, highly rational, loyal, and value fairness. Even though you have a good balance of masculine and feminine values and interests, you generally enjoy the world of men and traditional male activities. You probably are competitive. Surprisingly, in spite of your resilience, you are also quite sensitive, so that your feelings may get hurt more readily than others realize. You may have grown up with a parent who had high standards and was somewhat critical or judgmental of you. You learned from an early age to avoid criticism. Before you express anger or resentment, you analyze your feelings to make sure they are justified and above reproach. By the time you express your anger, you often have stored up a number of resentments, which infrequently leads to you becoming quite angry. You may find it hard to forgive because you are sensitive, and when people hurt you, the memory lingers a long time. You may also explain to people why your feelings are justified, which can make them feel defensive. Learn to ask for what you want and express resentments as you feel them, being careful to avoid others feeling blamed. Instead of telling someone, “You are always late,” for example, or “You never do your fair share,” make a direct “I” statement, for example, “I would like you to help with the housework,” or “I would like you to come home on time.”

567 Code

Male

Low 0 Home conflict, one interview only, wants reassurance only, lacks knowledge or information. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, lack of skills with the opposite sex, being nonresponsive or nonverbal, tension.

Low 1 Home conflict, wants reassurance only, nonresponsive or nonverbal, restless.

Low 2/3/4/8/ Home conflict, wants reassurance only.

Nothing Low Lacks skills with the opposite sex, home conflict, mother conflict, sibling conflict, wants reassurance only, nonresponsive or nonverbal, tense, indecisive, unhappy, worries a great deal, insomnia, confused.

- Note: Scale 5 coded high was infrequently associated with tension.

Female

Low 0 Socially extroverted, resistant in the interview.

Low 2 Socially extroverted.

Low 3 Cried in the interview.

Low 4 Shy in the interview.

Nothing Low Restless, headaches, 8+ conferences, distractible in study, sibling conflict.

- Note: Scale 5 coded high was infrequently associated with headaches and 8+ conferences.

(Drake & Oetting, 1959)

568 Code

Male

Low 0 Home conflict, aggressive or belligerent, lacks knowledge or information. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, lack of skills with the opposite sex, being nonresponsive or nonverbal, tension.

Low 1 Home conflict, restless.

Low 2/3/4/7 Home conflict.

Low 9 Home conflict, introverted or self-conscious or socially insecure.

Nothing Low Home conflict, indecisive, unhappy, worries a great deal, insomnia, confused.

Female

Low 0 8+ conferences, resistant in the interview, verbal, socially extroverted.

- Note: Scale 5 coded high was infrequently associated with 8+ conferences.

Low 1 8+ conferences.

- Note: Scale 5 coded high was infrequently associated with 8+ conferences.

Low 2 8+ conferences, socially extroverted.

- Note: Scale 5 coded high was infrequently associated with 8+ conferences.

Low 3 8+ conferences.

- Note: Scale 5 coded high was infrequently associated with 8+ conferences.

Low 4 8+ conferences, shy in the interview.

- Note: Scale 5 coded high was infrequently associated with 8+ conferences.

Low 7/9 8+ conferences.

- Note: Scale 5 coded high was infrequently associated with 8+ conferences.

Nothing Low 8+ conferences, restless, depressed, distractible in study, lacks skills with the opposite sex, mother conflict, father conflict, sibling conflict.

- Note: Scale 5 coded high was infrequently associated with 8-t- conferences, depression, father conflict.

(Drake & Oetting, 1959)

569 Code

Male

Low 0 Mother conflict, poor rapport, aggressive or belligerent.

- Note: Scale coded low was infrequently associated with poor rapport. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, shyness in the interview, lack of skills with the opposite sex, being nonresponsive or nonverbal, being nonverbal or a nonrelator, tension, indecisiveness.

Low 1 Mother conflict, poor rapport, restless.

Low 2/3/4/7/ Mother conflict, poor rapport.

Nothing Low Home conflict, mother conflict, poor rapport, insomnia.

Female

Low 0 Socially extroverted, vague goals, marriage oriented, resistant in the interview, verbal.

Low 1/2/3 Socially extroverted, vague goals.

Low 4 Socially extroverted, shy in the interview, vague goals, nonresponsive.

Low 7/8 Socially extroverted, vague goals.

Nothing Low Socially extroverted, vague goals, distractible in study, restless, 8+ conferences.

- Note: Scale 5 coded high was infrequently associated with 8+ conferences.

(Drake & Oetting, 1959)

57/75 Codes

Men with this codetype are described as indecisive, worrying, introspective, tense, unhappy, and needing reassurance. They may experience anxious episodes characterized by obsessive rumination over inadequacies and shortcomings. They are quick to be selfcritical, guilty, and self-recriminating, and some may report dysphoria as a consequence. They are easily embarrassed and bashful, get their feelings hurt easily, and frequently feel inadequate in their love relationships. Women rarely obtain this codetype, but when they do, they are more prone to guilt and anxiety than would be expected from a high Scale 5 elevation alone. Even so, they are often intellectually competitive. Considering the two-point codetype when Scale 5 is omitted may enhance the interpretation.

o Look for anxiety, tension, worry, dysphoria/depression, dependency, rumination, indecision, heterosexual relationship problems/marital discord, and ruminative fears of failure, history of suicidal ideation/attempts. Check third highest scale.

Male college students with this profile usually were tense, indecisive, unhappy, worrying, and wanting reassurance (Drake & Oetting, 1959).

In another study of college clients, the men usually complained about academic problems and interpersonal difficulties, especially with their girlfriends (King & Kelley, 1977).

Male

Low 0 Home conflict, one interview only, wants reassurance only, lacks knowledge or information. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, lack of skills with the opposite sex, being nonresponsive or nonverbal, tension.

Low 1 Home conflict, wants reassurance only, nonresponsive or nonverbal, restless.

Low 2/3/4/6/8/9 Home conflict, wants reassurance only.

Nothing Low Lacks skills with the opposite sex, home conflict, mother conflict, sibling conflict, wants reassurance only, nonresponsive or nonverbal, tense, indecisive, unhappy, worries a great deal, insomnia, confused.

- Note: Scale 5 coded high was infrequently associated with tension.

Female

Low 0 Socially extroverted.

Low 3 Cried in the interview.

Nothing Low Headaches, sibling conflict, distractible in study.

- Note: Scale 5 coded high was infrequently associated with headaches.

(Drake & Oetting, 1959)

Description:

Introspective, excitable, interpersonally sensitive, may have episodes of anxiety and depression, females show many interpersonal problems

Possible Diagnoses:

Schizoid, Passive-aggressive, Anxiety reactions

TREATMENT

Because of their psychological-mindedness, as predicted by the Scale 5 elevation, and their adherence to instructions, as predicted by the Scale 7 elevation, men are good psychotherapy candidates. Insightful and introspective, they do well with insight therapy as well as thought stopping, relaxation training, venting and catharsis. Self-esteem building and assertion training are useful.

THERAPEUTIC FEEDBACK LANGUAGE

For men: Your profile suggests that you are a sensitive, thoughtful, analytical man, with cultural, verbal, and aesthetic interests. You enjoy intellectual activity and are introspective, dutiful, and responsible. The profile also suggests you are prone to worry; you see every side of an issue and worry about how things can go wrong. You might even worry about philosophical issues and bigger world problems. You feel guilty easily, and can be indecisive sometimes because you're afraid of making a mistake. Perhaps you grew up with a female parent to whom you were strongly bonded, but who also demanded a lot from you. At the same time, you may have experienced unpredictable setbacks, or overloads of responsibility as a child that left you anxious in case your actions led to disappointing

others. You seem to be going through life a little more on edge and anxious than perhaps you want to be. Work with your therapist at understanding why you spend so much time worrying and anticipating negative consequences. Learn to switch off negative thoughts, especially worries about not being good enough. Use CBT to manage your anxiety.

For women: Your profile shows that you are an action-oriented, direct, and assertive woman who enjoys the company of men. Practical and sensible, when a problem arises, you generally like to move into action to solve it rather than to spend too much time talking about it. At the same time, your profile suggests that you are experiencing some anxiety, with a tendency to feel guilty, worried, and tense. Perhaps growing up you were close to a male figure who took pleasure in your ability to enjoy traditional male activities. At the same time, something may have precipitated a tendency in you to worry, think ahead, plan, and be concerned that some detail that you've overlooked could lead to disaster. It is easy for you feel guilty and blame yourself when things go wrong. Work with your therapist on understanding why you spend so much time worrying and anticipating negative consequences. Learn to switch off negative thoughts, especially worries about not being good enough. Use CBT to manage your anxiety.

578 Code

Male

Low 0 Introverted or self-conscious or socially insecure (78), home conflict, one interview only, wants reassurance only, nonresponsive or nonverbal (78), tense (78), indecisive (78), lacks knowledge or information, vague goals, confused, aggressive or belligerent.

- Note: Scale coded low was infrequently associated with indecisiveness. This pattern was infrequently associated with introversion or self-consciousness or social insecurity (5-0), lack of skills with the opposite sex, being nonresponsive or nonverbal (5-0), tension (5-0).

Low 1/2/3/4/6/9 Introverted or self-conscious or socially insecure, home conflict, wants reassurance only, nonresponsive or nonverbal, tense, indecisive, lacks knowledge or information, vague goals, confused.

- Note: Scale 5 coded high was infrequently associated with tension.

Nothing Low Introverted or self-conscious or socially insecure, lacks skills with the opposite sex, home conflict, mother conflict, sibling conflict, wants reassurance only, nonresponsive or nonverbal, tense, indecisive, unhappy, worries a great deal, insomnia, lacks knowledge or information, vague goals, confused.

- Note: Scale 5 coded high was infrequently associated with tension.

Female

Low 0 Insomnia, nervous, lacks self-confidence, socially extroverted, verbal.

Low 1 Insomnia, nervous, lacks self-confidence.

Low 2 Insomnia, nervous, lacks self-confidence.

- Note: Scale 2 coded low was infrequently associated with lack of self-confidence.

Low 3 Insomnia, nervous, lacks self-confidence, cried in the interview.

Low 4/6/9 Insomnia, nervous, lacks self-confidence.

Nothing Low Insomnia, headaches, nervous, exhaustion, depressed, 8+ conferences, lacks self-confidence, distractible in study, mother conflict, father conflict, sibling conflict, lacks skiUs with the opposite sex.

- Note: Scale 5 coded high was infrequently associated with 8+ conferences, depression, father conflict

(Drake & Oetting, 1959)

579 Code

Male

Low 0 Home conflict, mother conflict, one interview only, wants reassurance only, lacks knowledge or information, defensive, aggressive or belligerent, poor rapport.

- Note: Scale 0 coded low was infrequently associated with poor rapport. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, shyness in the interview, lack of skills with the opposite sex, being nonresponsive or nonverbal, being nonverbal or a nonrelator, tension, indecisiveness.

Low 1 Home conflict, mother conflict, wants reassurance only, nonresponsive or nonverbal, restless, poor rapport, defensive.

Low 2/3/4 Home conflict, mother conflict, wants reassurance only, poor rapport, defensive.

Low 6 Home conflict, mother conflict, wants reassurance only, poor rapport, rationalizes a great deal, defensive.

Low 8 Home conflict, mother conflict, wants reassurance only, poor rapport, defensive.

Nothing Low Lacks skills with the opposite sex, home conflict, mother conflict, sibling conflict, wants reassurance only, nonresponsive or nonverbal, tense, indecisive, unhappy, worries a great deal, insomnia, confused, poor rapport, defensive.

- Note: Scale 5 coded high was infrequently associated with tension.

Female

Low 0 Vague goals, distractible in study, marriage oriented, socially extroverted, sibling conflict, confused, nervous, exhaustion, verbal.

- Note: Scale coded low was infrequently associated with sibling conflict, confusion, exhaustion.

Low 1 Vague goals, distractible in study, socially extroverted, sibling conflict, confused, nervous.

- Note: Scale 1 coded low was infrequently associated with sibling conflict.

Low 2 Vague goals, distractible in study, socially extroverted, sibling conflict, confused, nervous.

- Note: Scale 2 coded low was infrequently associated with confusion.

Low 3 Vague goals, distractible in study, socially extroverted, sibling conflict, confused, nervous, cried in the interview.

Low 4 Vague goals, distractible in study, socially extroverted, shy in the interview, sibling conflict, confused, nervous, nonresponsive.

Low 6/8 Vague goals, distractible in study, socially extroverted, sibling conflict, confused, nervous.

Nothing Low Vague goals, distractible in study, socially extroverted, sibling conflict, confused, nervous, headaches.
(Drake & Oetting, 1959)

58/85 Codes

Men with this codetype are inner-directed and spend much time in thought, often engaging in philosophical musings or being concerned with abstract ideas about life's meaning. Most complain of feeling confused, unhappy, alienated from others, and having home conflicts. They may lack drive. (Considering the two-point codetype when Scale 5 is omitted enhances interpretation.)

Men with this codetype are likely to have family histories of alcohol abuse, mental illness, and physical abuse. Some of these men have psychiatric histories that began in childhood. Although many of them are not psychotic, they often report depression, paresthesia, and religious preoccupations. Although some can be seen as creative, others are described as odd, eccentric individuals, who have difficulties with emotional closeness. Sexual conflicts are common, as are family problems.

Women with this codetype display unusual thoughts and behaviors that often focus on issues of control of others in order to protect themselves. Typically they feel alienated. Among female adolescents, this pattern would be associated with behavioral problems at home or school, and/or legal difficulties.

- Immature, alienated, passive, dependent, depressed, schizoid, inappropriate affect, poor sexual adjustment. Look for a brutal, rejecting father, passive mother, an extensive prior psychiatric history, unstable employment, bohemian/nonconformist lifestyle, polydrug abuse, sexual and sexual identity conflicts, rumination, disrupted thinking and subtle (if not overt) thought disorder. Check third highest scale.
- For college students with this profile, men report being confused, unhappy, and having conflicts at home (Drake & Oetting, 1959).

Description:

Usually from abusive or dysfunctional families, may have odd or intrusive thoughts, shy, reserved, have family and sexual problems

Male

Low 0 Home conflict, lacks knowledge or information, aggressive or belligerent. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, lack of skills with the opposite sex, being nonresponsive or nonverbal, tension.

Low 1 Home conflict, restless.

Low 2/3/4/6/7 Home conflict.

Low 9 Introverted or self-conscious or socially insecure, home conflict.

Nothing Low Home conflict, indecisive, unhappy, worries a great deal, insomnia, confused.

Female

Low 0 Socially extroverted, verbal.

Nothing Low Lacks skills with the opposite sex, 8+ conferences, distractible in study, sibling conflict, father conflict, mother conflict, depression.

- Note: Scale 5 coded high was infrequently associated with 8+ conferences, father conflict, depression.

(Drake & Oetting, 1959)

TREATMENT

With men, their intellectual curiosity may make them amenable to self-analysis, but the therapist should use insight therapy judiciously since it may be disorganizing to the patient. It can also lead to endless intellectualization without

behavior change. Self-esteem building, self-assertiveness training, and reparenting-type therapies are suggested for both males and females.

THERAPEUTIC FEEDBACK LANGUAGE

For men: Your profile suggests that you are a thoughtful, analytical, sensitive man, who is interested in philosophy and creative ideas. At the same time, the profile suggests that as a child you may have experienced a parent who, at times, could be somewhat cruel, cold, or rejecting. You may have responded to this adaptively by attempting to understand them and by formulating a worldview that explains why people are cruel or cold to one another. Because you are comfortable analyzing people and events, you may spend a good deal of time thinking, daydreaming, and be somewhat withdrawn from others. Others may misjudge you as a little aloof or cold. Perhaps you're also cautious about letting down your guard and letting people get close to you in case they should treat you coldly. You are quite comfortable in the world of ideas and creative, abstract thoughts. Discuss with your therapist whether you experienced moments of emotional coldness or cruelty from a parent figure that led to you "shutting down" and withdrawing into the comfort of your inner world. Learn how to be more assertive, and to recognize what is loveable about you so that you can be more comfortable allowing people to get close to you.

For women: Your profile suggests that you are comfortable in the world of men. Practical and action-oriented, you want to problem solve when you are confronted with a problem. At the same time, your profile suggests that you are somewhat cautious about letting down your guard and letting people get close to you. Perhaps growing up you had a caretaker who treated you coldly or even cruelly. You may have felt different from others and responded adaptively by developing your own personal philosophy and way of viewing the world. That may have led you to be cautious in allowing people to get too close to you. Work with your therapist on learning to like yourself so that you can allow others to care for you.

589 Code

1. When the 5-8-9 pattern is present, the lack of academic motivation seen for males with the high 8-9/9-8 profile is not manifested. The 5 scale acts as a suppressor (Drake & Oetting, 1959).

Male

Home conflict, mother conflict, lacks knowledge or information, poor rapport, aggressive or belligerent.

- Note: Scale coded low was infrequently associated with poor rapport. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, shyness in the interview, lack of skills

with the opposite sex, being nonresponsive or nonverbal, being nonverbal or a nonrelator, tension, indecisiveness. The 89-0 coding is related to lack of academic motivation and poor academic performance; however. Scale 5 coded high with this pattern suppresses its effect on academic performance and leads to a higher grade distribution than would be expected from the base rate

Low 1 Home conflict, mother conflict, poor rapport, restless.

Low 2/3/4 Home conflict, mother conflict, poor rapport.

Low 6 Home conflict, mother conflict, poor rapport, rationalizes a great deal.

Low 7 Home conflict, mother conflict, poor rapport.

Nothing Low Home conflict, mother conflict, indecisive, imhappy, worries a great deal, insomnia, confused, poor rapport.

- Note: Scale 9 coded high was infrequently associated with indecisiveness and worrying a great deal.

Female

Low 0 Vague goals, marriage oriented, socially extroverted, restless, confused, 8+ conferences, verbal, resistant in the interview.

- Note: Scale coded low was infrequently associated with confusion; Scale 5 coded high was infrequently associated with 8+ conferences.

Low 1 Vague goals, socially extroverted, restless, exhaustion, confused, 8+ conferences, verbal, resistant in the interview.

- Note: Scale 5 coded high was infrequently associated with 8+ conferences.

Low 2 Vague goals, socially extroverted, restless, exhaustion, confused, 8+ conferences, verbal, resistant in the interview.

- Note: Scale 2 coded low was infrequently associated with confusion; Scale 5 coded high was infrequently associated with 8+ conferences.

Low 3 Vague goals, socially extroverted, restless, confused, 8+ conferences, verbal, resistant in the interview.

- Note: Scale 5 coded high was infrequently associated with 8+ conferences.

Low 4 Vague goals, socially extroverted, shy in the interview, restless, confused, 8+ conferences, verbal, resistant in the interview, nonresponsive.

- Note: Scale 5 coded high was infrequently associated with 8+ conferences.

Low 6/7 Vague goals, socially extroverted, restless, confused, 8+ conferences, verbal, resistant in the interview.

- Note: Scale 5 coded high was infrequently associated with 8+ conferences.

Nothing Low Vague goals, distractible in study, socially extroverted, lacks skills with the opposite sex, restless, confused, depressed, 8+ conferences, verbal, resistant in the interview, father conflict, mother conflict, sibling conflict.

- Note: Scale 5 coded high was infrequently associated with depression, 8 + conferences, father conflict.
(Drake & Oetting, 1959)

59/95 Codes

For men, the presence of an elevated Scale 5 reduces the likelihood of acting out, perhaps because of their increased capacity to intellectualize and be empathic. Some evidence suggests that men with this codetype do at least reasonably well academically. They are often colorful dressers with charismatic flair. Verbal, perceptive, and engaging, they are often seen as likable. However, they have a tendency to overcommit, (especially if the *Ma2* is elevated) and some may have difficulty with follow through. They are quite opportunistic, although not necessarily manipulative. In some cases, if Scale 9 is highly elevated, mood swings and possible mania can interfere with goal-oriented activity and interpersonal relationships. Problem areas tend to include emotional neediness and demands for constant attention. Men with this profile are driven by their need for approval, and require a great deal of reassurance. This is even more pronounced if Scale 3 is also elevated. Men with this profile can do well in people-related professions where sensitivity, empathy, and energetic charm are required, and their energy allows them to be intellectually and artistically productive.

For women, an elevated Scale 5 increases the likelihood of emotional reactivity shading toward verbal, if not physical, aggressiveness. These women typically are energetic, competitive, confident, uninhibited, adventurous, self-centered, and demanding. They can be quite intensely irritable when their goal-driven activities are thwarted or questioned. These individuals generally do not report psychological problems or distress. Active, energetic, and easily bored, they describe themselves as self-confident and easygoing. Generally, Scale 0 is low, reflecting social comfort and the fact that they often make a good social impression. Even if the *MAC-R* scale is not elevated, both males and females can be addiction-prone, using chemical agents as a way of modulating their energy level.

o Conflicts about dependency and assertiveness in men. Social aggression and competitiveness in women. Look for unstable employment histories and heterosexual relationships, prior arrests, narcissism, cynicism, guardedness, distractibility, suspiciousness, social and hostile aggression, amorality, and antisocial impulses/ conduct, hyperactivity, flight of ideas, grandiosity, impulsiveness, substance abuse. Rule out mania; narcissistic, antisocial, and paranoid personality features (e.g., ideas of reference, persecution).
Check third highest scale.

- Adolescents in treatment with the 5-9/9-5 pattern (Marks et al., 1974) were peaceable, rational, and ambitious. They had high aspirations and aesthetic interests. They also had relatively few school problems. However, emotional dependency and lack of self-assertiveness were problems for them and many were drug users. The Marks, Seeman, and Haller book should be consulted for further information concerning this pattern.
- Male college counselees with the 5-9 pattern present problems concerning conflicts with their mothers, especially when scale 0 is low (Drake, 1956).

Description:

Stimulation-seeking, easily bored, like to be in control, see themselves positively

Male

Low 0 Mother conflict, poor rapport, aggressive or belligerent.

- Note: Scale coded low was infrequently associated with poor rapport. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, shyness in the interview, lack of skills with the opposite sex, being nonresponsive or nonverbal, being nonverbal or a nonrelator, tension, indecisiveness.

Low 1 Mother conflict, poor rapport, restless.

Low 2/3/4 Mother conflict, poor rapport.

Low 6 Mother conflict, poor rapport, rationalizes a great deal.

Low 7/8 Mother conflict, poor rapport.

Nothing Low Home conflict, mother conflict, poor rapport, insomnia.

Female

Low 0 Vague goals, marriage oriented, socially extroverted, verbal.

Low 1/2/3 Vague goals, socially extroverted.

Low 4 Vague goals, socially extroverted, shy in the interview, nonresponsive.

- Note: Scale 9 coded high was infrequently associated with shyness in the interview.

Low 6/7/ 8Vague goals, socially extroverted.

Nothing Low Vague goals, distractible in study, socially extroverted.

(Drake & Oetting, 1959)

TREATMENT

In the absence of mania, these hypomanic individuals are generally productive and successful. In the presence of mania, medication to stabilize energy and impulsiveness, and to prevent the possible cycling into depression is often necessary. In the absence of mania, these individuals profit from coaching types of therapy where they are held accountable for the commitments they make, but also allow them to feel validated and approved. Men and women tend to be driven by needs for approval, often reflecting internalized caregiver expectations, and their beliefs that only great success can lead to love and acceptance. Help them discover their own goals versus their beliefs about what they should do in order to obtain others' approval.

For males, the mother–son relationship is sometimes a source of inner conflict. Even though they tend to extol their own virtues and appear confident, sometimes boastful, 59/95 individuals experience difficulties trusting that their accomplishments are “enough.” Gestalt exercises such as role-playing “bragging” to help them engage and celebrate accomplishments can be helpful in reducing their drive to be constantly productive and validated by others. Setting realistic goals and not overcommitting out of a need to please are therapeutic goals.

Women with a 59/95 codetype should explore their father–daughter relationship and its effect on their high competitive drive and need to vanquish competitors. They can also benefit from some of the above therapeutic strategies. Teach both men and women to manage their irritability when frustrated. Look for childhood histories of caregivers who were constantly motivating them to achieve and succeed. Explore childhood experiences associated with partial reinforcement reward schedules. Also, both men and women have a tendency to be quite demanding of their loved ones, demanding achievement and affection from them in ways that can lead to interpersonal conflict.

THERAPEUTIC FEEDBACK LANGUAGE

For men: Your profile suggests you are highly energetic, driven, competitive, and ambitious. You may have a tendency to overcommit. You are sensitive, creative, and intellectually curious. People with your profile are often seen as colorful, even flamboyant and charismatic. You enjoy creative and novel ideas, and you're comfortable in a sensitive, aesthetically-oriented environment. You're likely comfortable with women and enjoy some traditionally feminine activities. You may have grown up close to a female whose emotions and concerns you could readily understand. Perhaps one of your parents was always motivating you, or you felt an obligation to prove your family was successful through your efforts. You are also highly driven and impatient with a world that often moves too slowly for you. You have two speeds: “full speed” and “off.” You tend to be happiest when you have slightly too

much to do. Work with your therapist to determine when your energy level becomes counterproductive. Discover whether you are driven by your own ambitions or, instead, what you believe you need to achieve in order to obtain others' love and approval. Your therapist may suggest medication if your energy is counterproductive.

For women: Your profile suggests you are an energetic, ambitious woman who is comfortable in the world of men. You enjoy traditional male activities, and you are a practical, action-oriented, competitive woman who rejects stereotypic feminine interests and values. You think and move quickly, and operate at two speeds: "full speed" and "off." You probably get impatient with people who move or think more slowly than you do. People may see you as competitive to the point of being aggressive, and at times your energy is so high you may have difficulty completing things and following through on your commitments. You may have been close to a male figure growing up, and felt the need to achieve great things. Perhaps one of your parents was always motivating you or you felt an obligation to prove your family was successful through your efforts. Work with your therapist to determine whether your energy level ever becomes counterproductive. Discover whether you are driven by your own ambitions or, instead, what you believe you need to achieve in order to obtain others' love and approval. Your therapist may suggest medication if your energy is counterproductive.

50/05 Codes

Men with this codetype are introverted, intellectual, creative, and reject stereotypical male activities and interests. They respond to stress by interpersonal and intellectual withdrawal rather than reaching out to others. They are cautious, inhibited, anxious around strangers, and are overcontrolled and over-ideational. Socially, they are awkward and have difficulty in being assertive, and some experience low self-esteem. They are embarrassed easily and do not act out. They may experience sexual difficulties due to their passivity.

Women with this codetype are typically more retiring and less assertive than one would expect from an elevated Scale 5. Some are from working-class or rural backgrounds. Others are comfortable in traditionally male occupations that require little social interaction. Women may seek careers in engineering, the armed services, or other kinds of professions where their practical, problem-solving skills are valued. They are comfortable working in relative isolation. For both men and women, further interpretation can be done by omitting Scale 5 and examining the resulting two-point codetype.

o Cautious, inhibited, and overideational. Socially timid and avoidant. Heterosexual discomfort in men.

1. Adolescents in treatment with the 5-0/0-5 pattern (Marks et al., 1974) had intellectual interests. However, they were slow to make friends and were shy, timid, and submissive. They had conflicts about sexuality and asserting themselves. They tended to over-control their impulses. The Marks, Seeman, and Haller book should be consulted for further information concerning this pattern.
2. Male college counselees with the 5-0 pattern tend to show introverted behavior (Drake, 1956).

Description:

Introspective, schizoid, anxious, problems in sexual rel-s, see themselves as happy and well adjusted

TREATMENT

Research has shown that introversion and extraversion tend to be stable, heritable traits. Assertiveness training as well as social skill building can be useful. Both males and females can profit from coming to terms with being introverts and learning social skills appropriate to their work and interpersonal circumstances.

THERAPEUTIC FEEDBACK LANGUAGE

For men: Your profile suggests that you are a sensitive, intellectual, creative, aesthetically oriented man who is somewhat shy. You tend to avoid large groups of people you do not know, and you're most comfortable with small groups of like-minded people. You need time alone, can feel "burned out" by too much socializing, and find making small talk to be stressful. Some people with your profile are able to take on an interpersonal leadership role in front of others if it involves a structured task. At times you may hang back and lack assertiveness, not "speaking up" to protect your own interests until you feel compelled to do so. Explore with your therapist whether your shyness and empathy for others hinders you in your professional or interpersonal relationships. Rehearse certain social situations so that you become comfortable with small talk when you need to do so.

For women: Your profile suggests that you are a self-sufficient, introverted, practical, sensible, and action-oriented woman who's quite comfortable working alone. You dislike small talk and too much socializing with new people. Women with your profile are often comfortable in professions where you solve practical problems and have autonomy without the need for much social interaction. You probably have been this way most of your life, and if these traits are causing any difficulty, practice with your therapist learning how to relate to new people in unstructured social situations.

Scale 6: Paranoia (Pa)

Descriptors

Complaints

Feeling criticized, judged, attacked; possible paranoid ideation; feeling misunderstood or unfairly treated; fear of attack; hurt feelings; possibly depressed; interpersonal difficulties; personalizes; resentments toward family

Thoughts

Suspicious, opinionated, moralistic and judgmental, selfrighteous, possible ideas of reference, ideas or delusions of persecution, rigid, fair-minded

Emotions

Highly sensitive, resentful, angry, feels unfairly treated, rationalizes, unforgiving, vindictive

Traits and Behaviors

Values loyalty, argumentative, stubborn, hypersensitive, selfrighteous, judgmental, distrustful, hypersensitive, possible paranoid ideation or delusions

(Levak, Siegel, Nichols, & Stolberg, 2011)

Therapist's Notes

Normal-range Scale 6 elevations suggest a sensitive, rational, analytical individual who values loyalty and meticulous fairness. These clients can be rigid and highly sensitive to any kind of inferred criticism or unfair demands.

Elevations on the subscales of Paranoia (Pa) refine the normal range interpretation. Persecutory Ideas (Pa1) elevations may be associated with a recent accusation of wrongdoing, so paranoid item elevation accurately reflects a current situation. Poignancy (Pa2) elevation suggests a tendency to personalize and readily feel hurt, misunderstood,

and lonely. Pa2 elevations also suggest the storing of resentments, difficulties with assertion, and a propensity to be vindictive if slighted. When the Naïveté subscale (Pa3) is elevated, individuals tend to be morally “black-or-white,” rigid, moralistic, and naïve about other people’s tendency to be self-serving, rationalizing, and insensitive. They deny hostility, which tends to be expressed as a rationalized resentment.

Scale 6 elevations reflect a fear of criticism, judgment and, at higher elevations, a fear of attack and subjugation. Individuals preoccupied with protecting themselves against unfair treatment would adaptively become susceptible to anything that can be construed as disparagement or condemnation. As Scale 6 elevates above a T-score of 65, individuals’ sensitivity toward criticism, derision, or control can shade into paranoia, especially if supplementary scales suggesting paranoid ideation are elevated. These individuals are often analytical and are preoccupied with fairness to the point of mean-spiritedness. They rationalize their actions, perceive implied disapproval, and defend against it preemptively. They do not express their wants, their needs, or their resentments directly until they feel fully justified in doing so, by which time they are angry and unforgiving. They tend to repress emotions that could lead others to find fault with them. At high elevations, paranoia may manifest itself in preoccupations with powerful agencies, such as the Central Intelligence Agency (CIA) and Federal Bureau of Investigations (FBI), conspiracies, enemies who are stealing from them, or other manifestations of fear of being attacked and subjugated. When hurt or slighted, a desire to punish, a slowness to forgive, and a desire to label the person who has hurt them as “bad” or “evil.” This reflects the intensity of their hurt feelings and their need to justify their anger. When not threatened, high 6 individuals can be empathic and highly emotionally responsive. Individuals with high Scale 6 elevations value loyalty and are unforgiving of transgressions. They tend to be fastidious about appearance and may be unconsciously seductive, perhaps preemptively minimizing criticism. Others, responding to this unconscious coyness, elicit surprise and disdain from the high 6, as it would suggest conscious impropriety. High 6s tend to remember slights and injustices after others have resolved them, and so they rehash old resentments during current arguments as a way of rationalizing their anger.

Even at moderate elevations, guardedness and suspicion can lead to difficulties in work, marital situations, and families. In the presence of paranoid ideation, referrals due to workplace violence concerns can occur. Graham, Ben-Porath, and McNulty (1999) report that elevations on Scale 6 may indicate symptoms of dysthymia, depression, and suicide attempts.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Lifestyle and Family Background

Our hypothesis is that high levels of vigilance for criticism, judgment, or actual physical attack reflect an adaptive response to a childhood in which caretakers were critical, shaming, and severely punishing or had standards

that were impossible to achieve. In some cases caretakers may have withheld affection unless unrealistically high standards of behavior were met. In other cases caretakers may have been verbally or even physically abusive as a way of disciplining “bad” behavior. This may have instilled a determination to be above criticism or contempt, identifying with the aggressor and developing a similarly rigid set of values and beliefs. These clients tend to be quite punitive and harsh with their own children.
(Levak, Siegel, Nichols, & Stolberg, 2011)

High scores ($T \geq 65$), a Spike 6 profile, reflects an individual who is highly sensitive, takes things personally and is suspicious of others’ motives. These individuals can sometimes store resentments in a way that might be described as “injustice collecting.” The interpretation of Scale 6 depends on the relative elevations of the Scale 6 subscales. In some cases, Scale 6 is elevated by mostly *Pa2* and/or *Pa3* subscales, with a lack of elevation on *Pa1*. In such cases, there is little evidence of paranoid ideation and feelings of persecution. Even without an elevation on *Pa1*, however, an elevated Scale 6 would suggest an individual whose sensitivity can shade toward paranoia when stressed, with paranoid jealousies, misunderstanding of others’ motives, and ideas of reference. Projection tends to be a primary defense mechanism. When *Pa1* is also elevated, then delusions of persecution are likely. In cases with all three subscales elevated, a paranoid disorder is suggested. Some individuals, especially if they also score high on *K* and *Es*, can function relatively well for periods of time. Others may view them as “touchy,” easily hurt, and quick to take retaliatory action against what might seem minor slights, but not as clearly paranoid. However, their sensitivity to criticism or any demands placed on them, and their tendency to be self-protectively argumentative about the fine points in an interaction, can eventually lead to interpersonal difficulties. A high 6 individual sees the world as a potentially dangerous place where “good people” can be trusted and “bad people” can’t. Consequently, they constantly evaluate others to see where they fall on that continuum. Others may see them as rigid, judgmental, or egocentric, since they determine who is good and bad based on their own emotional needs and vulnerabilities. High 6 individuals are argumentative and, because of this, tend to create arguments. They approach conflict as if they are defending themselves, rather than involved in a negotiation to resolve a problem for mutual satisfaction. They frame their wants, perspectives, and desires as justified on moral grounds. This leads others to argue and present the moral justification for their own perspective. A high elevation on Scale 6 with all subscales also elevated may reflect a psychotic disorder. In such cases, a preoccupation with the CIA, FBI, or even extraterrestrial malevolent forces would reflect the level of their internally experienced vulnerability, and the adaptive defensive response of appealing to higher powers and magical properties in order to protect themselves. Since the advent of reality television, there have been a number of cases of young people experiencing a paranoid reaction to stress by believing they were the stars of a reality TV show. Their paranoid construct, confirmed by what appeared to be TV

episodes directed at them, maintained their belief system for long periods of time in a similar way to paranoid delusions about CIA spies shaped during the Cold War.

Moderately high scores ($T=55-65$) reflect an individual who is sensitive, loyal, highly rational, analytical, and easily hurt by what they see as others' failures of empathy. They exhibit a tendency to take things personally and, under severe stress, misinterpret others' motives as consciously malevolent. The subscales are particularly useful in this range to tease out the relative contributions of the various components of paranoia. Sometimes Scale 6 is elevated in this range if an individual has been accused of a crime or a humiliating error. In this case it might reflect a heightened sensitivity to criticism, and feeling unfairly accused. Spike 6 individuals, even in the moderate range, can become self-defeatingly preoccupied with obtaining justice for a perceived slight or transgression. However, elevations in this range most often suggest a rational, analytical, fair-minded, and somewhat fastidious individual who can be subtly judgmental, which in turn elicits judgment from others.

Low scores ($T \leq 35$) are rare. A very low score suggests a cynical individual who sees most people as self-centered, self-absorbed, selfish, and ready to exploit any advantage over others.

Black was able to identify a sizable group of college women with codes in which scale 6 was the lowest value. As a group these women were perceived by their peers as socially withdrawn and in poor rapport with others. The terms that they used to describe the low 6 girl include shy, timid, and seclusive. These girls were also seen as rough and awkward, deliberate, thoughtful, inflexible, idealistic but humble, and both self-distrusting and self-dissatisfied. Consistent with this picture, the terms that were very infrequently ascribed to the low 6 girls were sociable and worldly, cheerful and laughterful, high-strung and aggressive, adaptable and unemotional.

In their self-descriptions, the low 6 girls also endorsed the terms rough and arrogant, as well as the terms secretive, modest, and self-effacing, all of which are quite similar to the implications in the peer ratings. However, in addition they used rather frequently a term that the peer group avoided, aggressive, and added several similar terms including cynical, shrewd, hardhearted, arrogant, and rebellious. At some variance with the foregoing terms are the final two adjectives included in Black's findings, relaxed and cooperative. This group significantly avoided describing themselves as sentimental. Anderson (1956) also noted the role of low 6 in the poor response of these subjects to counseling in a university counseling center.

(Dahlstrom, Welsh, & Dahlstrom, 1979)

o Overt paranoid trends, often with manifest well-organized and elaborate delusions of persecution, control, or both. Rigid, resentful, hyper-vigilant, and hyper-rational. Denies suspiciousness, personal problems, and distress unrelated

to primary delusion. Lack of insight usually severe. Look for history of seclusiveness, alienating others, hostile outbursts.

Profiles with peak scores on scale 6 are relatively rare, scale 6 often being lowest in rank of the various clinical scales among normal and clinical samples (see Appendix M). However, scale 6 peaks almost invariably appear more frequently in female groups than they do in male samples. According to Black, high-point 6's for women show a relative rise in the late adolescent period.

In his analysis of college girls with peak scores on scale 6, Black found that they were perceived by their peers as shrewd, hardhearted, and clever. They also appeared to be affected and poised, high-strung and submissive. In addition the girls in this group were rated as either mature or infantile —depending on the subordinate peak paired with scale 6. If either scale 3 or 7 was paired as a high point with a scale 6 peak, the girl tended to be judged mature. If the second high point was scale 1, 8, or 9, on the other hand, the girl was rated infantile. Black also found that high-point 6 girls were frequently described as either grateful or rebellious. The manner in which this group's self-descriptions differed from those of college girls in general was more clear-cut. The high-point 6 girls included two of the same terms applied to them by their peers: affected and submissive. They added several other rather derogatory terms: arrogant, fickle, boastful, ruthless, and unrealistic. They further described themselves as being shy, timid, and naive, but nevertheless sociable, and as being contented, conventional, unemotional, and persevering. They avoided endorsing either practical or easily bored. Mello and Guthrie reported that there were too few cases in their college counselee sample to establish any pattern for peak 6 profiles. Guthrie found that medical patients with peak scores on scale 6 typically presented complaints centering around the gastrointestinal tract, with epigastric distress most common. They established poor rapport with the physician, disliked talking about their emotional problems, and frequently did not return for follow-up visits. They had long-standing problems centering around hostility and resentment toward members of their family. Their response to treatment was poor. Characteristics associated with special configurations in this group are summarized below.

(Dahlstrom, Welsh, & Dahlstrom, 1979)

Modifying Scales

- When Ideas of Persecution (RC6) is elevated, look for a paranoid disorder.
- Authority Problems (Pd2), Antisocial Practices (ASP), or Antisocial Behavior (RC4) elevated would suggest the possibility of acting out.

■ When Inability to Disclose (TRT2), is elevated, the suspiciousness and paranoia may interfere with the development of the basic trust needed for psychotherapy.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Female

Low 0 Socially extroverted, resistant in the interview.

Low 2 Socially extroverted.

Low 4 Shy in the interview.

Low 5 Physical inferiority.

o **Check:** *RC6*, *OBS* (low), *CYN1* (low), *CYN2* (low), *ASP1* (low), *TPA1* (low), *TPA2* (low), *FAM1* (low), *Pa1*, *Pf1*, *Pf2*, *Pf3*, *Pf4*, *Pa2*, *Pa3*, *Sd*.

Description:

Openly distrustful and suspicious or clinically paranoid

TREATMENT

Since an essential issue with Spike 6 individuals is trust, the therapist has to win the patient's trust by being meticulously trustworthy. A high 6 patient will often be vigilantly aware of what the therapist says and does, and their stated procedures and therapeutic goals. Deviations from what the therapist has stated will likely be noted by the high 6 patient in anticipation of future conflict, or an injustice that may result from their therapeutic interaction. Because these patients tend to articulate their fears, concerns, and wants as rationalized demands rather than requests, they can be intimidating to treat. If the therapist views the patient in the context of their childhood conditioning experiences, this may minimize negative counter-transference. Typically, these individuals grew up in environments where a parent was extremely strict, using judgment, shame, blame, and sometimes harsh physical punishment as a way of controlling the child. In many cases, the harshness of parental discipline occurred without great hostility, but rather was administered with an air of righteousness. Repeated thrashings to "drive the devil out," and severe punishments to "teach the child a lesson," as well as verbal tongue-lashings and shaming punishments, served to instill in the child a hyper-alertness to anything that can be construed as criticism. Once the therapist sees the patient as vigilant out of fear, the therapeutic process can focus on soothing the patient's anxieties around anticipated therapist criticism or judgment. Be aware that the patient's seemingly innocuous questions about therapeutic procedures usually reflect a specific concern, and dealing with the transference on a weekly basis can be

useful. Therapists must monitor their own defensiveness when the patient is subtly confrontational and critical of them. Help the patients understand that their high values and rigid moral standards are understandable, given their early conditioning experiences. Help them see how they are sensitive compared to other people, and therefore more likely to take things personally. Educate them as to how others can be insensitive out of a lack of awareness rather than willful hostility. Explore experiences of shaming punishments and unfair treatment by others, and encourage catharsis and self-empathy. Cognitive behavioral techniques can help them to be less sensitive and to take things less personally.

Treatment: Rule out Delusional Disorder (*paranoia vera*). Partially responsive to antipsychotic medication and nonspecific milieu treatments. Interpersonal therapy is sometimes helpful following partial response to medication and restoration of affect.

Therapy and Therapeutic Pitfalls

Clients with high Scale 6 are often seen as difficult to treat because they are sensitive to criticism and may view insights as shaming. They can be highly rational to the point of being argumentative, replicating their relationship with a punitive and demanding parent. Overt paranoid symptoms may require medication, but would likely be resisted. Exploring current feelings of vulnerability to attack or judgment could be validating. Paranoid symptoms, if Scale 8 is unelevated (especially if Lack of Ego Mastery Cognitive [Sc3] is low), are usually fixed and rational rather than diffuse or disorganized. Although perhaps exaggerated by hypersensitivity, there is sometimes a basis for the paranoia. It is important to validate and affirm these clients' reactions without endorsing paranoid beliefs (e.g., "No wonder you are so frightened and self-protective given how attacked, criticized, or judged you feel").

Often these clients will express hurt and rationalized resentments toward specific people. Explore childhood episodes of unfair and harsh punishments or criticisms to develop self-empathy. Use gestalt role-playing techniques in which old injustices, wounds, and repressed anger are ventilated. Empathy for themselves as vulnerable children who wanted to be "above reproach" may develop more empathy for others. Help clients identify their wants and desires, learning to express themselves without blame or criticism of others. Teaching them to be assertive before resentment develops is a useful behavioral-cognitive tool.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Treatment and Self-Help Suggestions

1. Learn to ask for what you want before you are resentful and angry. You don't have to justify yourself. Avoid trying to explain to others why they "owe" you something because that will make them defensive.

2. You are afraid to ask for things in case other people use it to control you and make unreasonable demands on you. See if you can identify any “cognitive distortions” that are triggering this belief. Because you work so hard to protect yourself, this may trigger “mind reading,” where you assume that you know what other people are thinking and how they will act. Work with your therapist to explore where these ideas came from, and then develop some alternate ways of thinking.¹

3. Learn to express anger when you feel it. Don’t try to rationalize it or wait until you feel justified in expressing it. By the time you feel justified, you are very resentful, and then it’s hard for you to forgive the other person. Learn to verbalize your anger assertively. Define what it is that you want to express, and don’t assume that the other person will know what you want. When practicing assertiveness it may help to write it down. Use “I” statements to communicate how you feel without blaming someone else. For example, try saying “I’m feeling frustrated,” instead of, “You frustrate me.”

4. Explore with your therapist childhood experiences where you felt unfairly criticized and judged. See if you can develop empathy for yourself as a child, exploring specific situations where you felt unfairly treated. Role play getting angry with the person who mistreated you as a way of gaining empathy for yourself.

5. Resilience building: Forgiveness is not easy or quick, but the ability to do so leads to less anger, less stress, more optimism, and even better health.² An exercise to help with forgiveness is to “rewrite” the offense using a more “positive” approach.³ Write about any benefits you may have gotten from someone’s transgression against you (e.g., a rude sales clerk saved you money because you left the store before you finished the purchase). This can be a creative way to foster a more positive outlook.

6. Be aware that you are quite sensitive so you might take things personally that were not meant to be so. Your therapist may suggest the option of using medication to alleviate your extreme sensitivity. Be honest with your therapist about any ambivalence you might have about taking medication.

7. At times your sensitivity may shade toward paranoia when you’re unsure about who’s for you and against you. If you’re going through such a period, it might be quite frightening because it’s hard for you to trust your judgment. Discuss with your therapist if you’re feeling unable to trust him or her.

8. During this time of stress, make sure you exercise, eat healthy, and avoid alcohol and chemical agents. Exercise, especially aerobic exercise, can help reduce stress and also can help improve your mood.⁴

9. Be aware that you have a tendency to look at life in black-and-white terms. That made sense growing up when you tried hard to avoid criticism, judgment, and attacks by meticulously following rules, but discuss with your therapist how you might now inadvertently come across as rigid and judgmental toward others.

¹ It may help to explain the “ABC” concept of rational emotive therapy (Ellis & Dryden, 1997) where an event (A) leads to a thought (B), which then leads to an emotion (C). The clients can then recognize that although they feel as if the situation is making them angry, it is actually their interpretation of the event that leads to their negative feeling.

² In a study of 259 adults who had experienced a transgression, the subjects who completed a 6-week forgiveness program compared with a control group were significantly more likely to experience less negative thinking, less anger, and more positive health markers (Harris et al., 2006).

³ People who wrote about benefits they may have gotten from something negative someone did to them (as opposed to writing about their feelings or about some other topic) tended to forgive more easily (McCullough, Root, & Cohen, 2006).

⁴ Results of cross-sectional and longitudinal studies consistently find that aerobic exercise has antidepressant and anxiolytic effects. It also can protect against harmful effects of stress (Salmon, 2001).
(Levak, Siegel, Nichols, & Stolberg, 2011)

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you are a very rational, analytical, loyal, and fair-minded person. It is important for you to be seen as doing the right thing, and you work hard to be above your own and others’ criticism. You have high standards and you tend to be your own worst critic in anticipation of how others may criticize you. People with your profile often grew up in environments where a parent may have been quite critical, shaming, judgmental, and punishing, as a means of control. From an early age you learned to try to be above criticism. You are quite sensitive, so that injustice, unfair criticism, or any kind of humiliation is particularly painful. At times people may have “accused you” of being too sensitive. Your sensitivity may well be genetic and is not a negative quality. However, many people lack your kind of sensitivity, and can often hurt you by their clumsy and unaware behavior, when they genuinely mean you no harm. Because you are sensitive and try hard to be above criticism, if others hurt your feelings it takes you a long time, if ever, to forgive them. Loyalty is very important to you, so if someone is disloyal, it is hard for you to trust them again. Since you dislike conflict and want to be above criticism, you may find yourself

collecting hurts and injustices, waiting until you feel “justified” before you confront someone. By the time you are comfortable expressing your anger, hurt, and sense of being treated unfairly, you are quite angry. Because you want to be seen as fair-minded, when you are angry you try to explain to the other person what they have done “wrong.” If you have a request of others, you may explain to them why what you want is reasonable and fair, and how you are not really making a request of them, but only demanding what is your right. Because you are going through life protecting yourself against criticism and judgment, others may feel criticized and feel the need to argue rather than negotiate with you. Growing up, one of your parents may have had a tendency to be quite critical, judgmental, and punish you at times that you felt were unjust. Work with your therapist to understand how you, like a number of people, experience heightened sensitivity to criticism. When you experience feelings of being wounded and unfairly treated, learn to switch these feelings off and to remind yourself that maybe your “sensitivity” is working overtime. Learn to ask for what you want before you feel resentful. When you are angry, try to tell people what you are angry about without telling them what they did wrong.

Feedback Statements—Elevated Profiles (T-Score > 65)

Strengths

Your profile suggests you have a number of strengths. You are rational, fair-minded, and loyal. You have high personal standards, and you work hard to be above criticism or judgment. You have strong values, and you may be very black-and-white about the right and wrong way of seeing and doing things.

Sensitive to Criticism and Judgment or Paranoia

You are susceptible to anything that can be construed as criticism or judgment. Currently you may feel on edge and tense, as if someone is going to unfairly criticize or attack you. At times, your sensitivity can shade toward paranoia so that it is hard for you to know whom to trust. These times might be quite frightening because you don’t know whether your mistrust of others is due to your sensitivity or whether you are truly seeing things clearly.

High Personal Standards or Feels Unfairly Treated

People probably see you as having high personal standards, and you work hard to be above reproach. People with your profile have a keen sense of justice. If you feel unfairly treated or if you feel others are mistreated, it makes you angry, and you feel driven to “right the wrong.” If people hurt you, even though you may forgive them, it is hard for you to forget what they have done.

Rationalized Resentments

You tend not to let others know when you are hurt or angry until you feel you are completely justified in doing so. However, by that time you are angry and have hard feelings about the other person not being sensitive to your needs. You may store and rationalize your resentments without letting people know how you feel, and if they continue their actions you begrudge them and feel bitter. You don't ask for what you want until you feel you fully deserve it. Because you are so sensitive to the issue of fairness, when you finally express your feelings you may try to explain why you are feeling hurt or angry. This is your way of justifying yourself; however, it makes others feel defensive, so they tend to argue back.

Slow to Forgive

If people let you down or you feel unjustly treated it is difficult for you to forgive them. You may feel a need to punish people if they have hurt you. This is because you experience feelings intensely, so painful events sting and cut deeply. When you are angry with people, you tend to see them as evil or bad, and you keep them at a distance and perhaps justify why you need to punish them.

Lifestyle and Background Feedback

Typically, people with your profile had caregivers who were critical, shaming, judgmental, and severely punishing. They may have had high standards so that you always felt subtly or overtly criticized or judged. Perhaps you had to endure verbal or even physical punishments that were will breaking and shaming, which made you feel emotionally knocked down and crushed. From an early age, you learned to protect yourself by wanting to be above reproach, by doing everything right, and by making sure that you were not punished. You learned not to express anger because it could lead to retaliation by a parent figure. No wonder you avoid expressing vulnerable feelings. Growing up feeling humiliated and judged, you go through life ready to defend yourself, making notes of others' flaws, and storing them away as ammunition should you need to protect yourself against them.

Normal-Range Feedback (T-Score 50 to 65)

Your profile is in the normal range. It suggests you are a sensitive person who tries hard to be above criticism. You tend to be your own worst critic, so disapproval is particularly painful for you. You work hard to "do the right thing" and meeting other's expectations is important to you. You are inquisitive, rational, and analytical. Since you want to be above reproach, you sometimes allow anger or frustration to build until you feel completely justified in expressing

it, but by that time you are quite angry and resentful. Anger can come out as sharp rebukes, rather than you expressing it directly. People with your profile are sensitive to being controlled and value independence. You have high standards and are fair-minded. If people are disloyal or unfairly critical it can be hard for you to forgive. In an argument you are acutely aware of who said what to whom and you can't let go of a dispute until it has been resolved fairly. You may have had parents who could be somewhat critical with a tendency to use shaming as a parenting tool, so no wonder you are sensitive to being controlled or criticized.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Relations with Other Scales

61/16 Codes

See 16/61 Codes.

62/26 Codes

See 26/62 Codes.

Guthrie found that this group of patients showed serious emotional difficulties, overshadowing any particular medical problem that they may have presented initially, even though they were typically very worried and concerned about their physical difficulty. They were depressed, with a strong underlying trend of hostility. They had long histories of interpersonal difficulties and rejection of close associations, their hostilities seemingly handicapping them significantly in social skills. When seen such patients were severely psychoneurotic, a small subgroup of them appearing actually prepsychotic. Guthrie also noted that they tended to be more disturbed than their moderate elevations on the MMPI profiles would indicate. The height of the F scale, however, did seem to be proportional to the severity of their disturbance.

(Dahlstrom, Welsh, & Dahlstrom, 1979)

63/36 Codes

See 36/62 Codes.

Medical patients with this pattern were described by Guthrie as rigid, worrying, defensive, and uncooperative. They resented any implication that their difficulties were psychogenically determined, and usually failed to return when

this was suggested. They had histories of medical shopping from one physician to another. Paranoid features were frequently apparent on the first contact; several subjects were considered to be clearly prepsychotic. (Dahlstrom, Welsh, & Dahlstrom, 1979)

6-3 See the 3-6 combination, p. 129.

When the 6 scale is higher than the 3, a hostile egocentric person who is struggling for power and prestige is likely. He/she tends not to recognize the hostility (Lachar, 1974).

64/46 Codes

See 46/64, 462/642, 463/643, and 468/648 Codes.

Data on 64 and 642 patterns are included in the 46-64 and the 462-642 code types presented in the Marks and Seeman Atlas.

6-4 See also the 4-6 combination, pp. 150-152.

Marks et al (1974) found the 4-6/6-4 pattern in a university hospital and outpatient clinic. It was primarily a female pattern. These females were described as self-centered, hostile, tense, defensive, and irritable. They usually handled their difficulties by refusing to admit them, and frequently they used rationalization as a primary defense mechanism. The Marks, Seeman, and Haller book should be consulted for further information concerning this profile.

642 Code

1. Marks et al. (1974) found the 4-6-2/6-4-2 pattern in a university hospital and outpatient clinic. It was primarily a female pattern. A woman with this pattern tended to be acting out, depressed, critical, and skeptical. The Marks, Seeman, and Haller book should be consulted for further information concerning this profile.

65/56 Codes

See 56/65 Codes.

67/76 Codes

This infrequent code most often has Scale 2 or 8 as the third or fourth highest scale. People with this profile are hypersensitive, tense, anxious, dysphoric, alienated from others, and can obsessively collect injustices. They are extremely concerned about criticism or disapproval, and are preoccupied with avoiding failure. The profile reflects an individual who is continually on edge and fearful, ruminating about how to avoid being criticized or judged. They obsess about who said what to whom, and what was really meant in relationship to them. They often present with interpersonal problems because of their extreme sensitivity, and need to constantly and defensively rationalize and justify their behaviors. Although insecure, with low self-esteem, and quick to feel guilty, they are also quick to defensively judge others. Ordinary interactions can become arguments because 67/76 individuals tend to position their requests or disappointments as resentments, perceived slights, or defensive arguments. Small misunderstandings about irrelevant details can degenerate into laborious justifications, which others perceive as subtle criticisms of them. 67 individuals experience guilt and are intropunitive. Their moods can be dysphoric due to their constant sense of apprehension. They can be distractible and indecisive since they try to see all sides of an issue, and are preoccupied with the avoidance of failure and criticism. They obsess and ruminate about how others see them, the righteousness of their own feelings, and what level of guilt or resentment they should be feeling. In rare cases, the profile can indicate a paranoid disorder. Some report intrusive ideas with religious preoccupations that reflect their needs to be absolved from guilt. They have difficulty with basic problem solving because they are both compulsive and rigid. Any perceived setbacks or shameful failures can lead to impulsive suicide, especially if suicide items are endorsed.

o Severe anxiety, tension, and dysphoria but with concurrent anger and intropunitiveness. Feels isolated, trapped by feelings, and terrified of losing control. Mood is depressed and hopeless—often desperately so—with sleep disturbance and exhaustion. Distractibility and indecisiveness secondary to intensity of mood and sense of suffering. Obsesses and ruminates about guilt, misery, rage, current predicaments, and loss of control and ensuing catastrophe. May consider suicide as a way to relieve intense suffering. Fears criticism and disapproval; may be hypervigilant. Psychotic/paranoid symptoms not uncommon, especially hypersensitivity, intrusive thoughts, hyperreligiosity, ideas/delusions of reference, or a combination of these. Problem-solving approach is narrow, compulsive, and nonresourceful. Tends to be rigid and stubborn, with stress only increasing these trends. Tends to internalize criticism and slights but also develops resentment over them. Sensitive to perceived unfairness; quick to feel unfairly judged, criticized, and hurt. Lacks skills to state grievances and negotiate conflicts; is unassertive. May have severe but unreported and poorly recognized conflict with significant other. Risk of impulsive suicide. Look for marital conflict/dissatisfaction; history of head injury, seizures, or both; compulsive rituals; and substance abuse to relieve anxiety or insomnia.

1. When 6 is elevated above the 7 scale, the person is attempting to change his/her perception of the world through the use of projection (Trimboli & Kilgore, 1983).
2. Counselors rated college men with this pattern plus no elevation of scale 5 as non-responsive and had difficulty relating to them. These clients also had problems at home and were confused and worried. College women were restless and had conflicts with their siblings (Drake & Oetting, 1959).
3. Kelley and King (1979a) found the 6-7/7-6 code type primarily for women clients in one college counseling center. Although they tended to have genito-urinary problems, crying moods, feelings of inferiority, and were described as rigid, they did not have any consistent diagnosis or pattern of pathology.

Description:

Anxious, tense, guilt-prone, ruminative, hypersensitive, use obsessive-compulsive defenses, misinterpret others

Possible Diagnoses:

Obsessive-compulsive dis., Multiple phobias, Anxiety reactions, Affective dis., Avoidant dis.

Male

Low 0 One interview only, lacks knowledge or information.

Low 1 Nonresponsive or nonverbal.

Nothing Low Lacks skills with the opposite sex, home conflict, mother conflict, sibling conflict, nonresponsive or nonverbal, tense, indecisive, unhappy, worries a great deal, insomnia, confused.

Female

Low 0 Socially extroverted, resistant in the interview.

Low 2 Socially extroverted.

Low 3 Cried in the interview.

Low 4 Shy in the interview.

Low 5 Physical inferiority, indecisive, lacks self-confidence, exhaustion, nervous, anxieties, headaches, insomnia, socially insecure.

Nothing Low Restless, headaches, 8+ conferences, sibling conflict.

(Drake & Oetting, 1959)

o **Check:** *RC7, ANX, FRS1, OBS, DEPI, DEP2, DEP3, DEP4, BIZ1, ANG1, ANG2, TPA1, LSE1, LSE2, FAM1, AGGR (low), PSYC, RC6, NEGE, PSYC – NEGE, Dr1, Dr4, Dr5, Hy3, Pd4, Pd5, Pa1, Pf1, Pf2, Pf3, Pf4, Pa2, Pa3, Sc1, Sc2, Sc3, Sc4, Sc5, Sc6, A, R, APS, MDS.*

TREATMENT

These individuals generally have misgivings about therapy and feel very vulnerable disclosing personal and intimate details. Look for childhood experiences of being unpredictably shamed, judged, or severely punished. Supportive therapy and CBT to help them develop a more realistic self-image can be useful. Thought stopping, relaxation training, and assertiveness training can also be useful. Insight therapy can be helpful because these individuals are usually highly rational and analytical. Help them develop empathy for themselves as children who tried to be “above criticism.” Help them to see how they adapted by going through life as if all interactions require them to defend themselves, rationalize their behavior, or preemptively judge others. Using CBT, work with them to understand that being constantly on guard against criticism was an adaptive response to being shamed and criticized, and that this response no longer needs to be constant and instinctive. Role-play with them how to express anger directly, without blaming others.

o **Treatment:** Rule out Major Depression; seizure disorder. Biological therapies usually necessary to relieve severe discomfort and attenuate suicide risk. Individual and marital therapy are helpful and motivation is usually high. Consider neuropsychological evaluation.

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you are a sensitive, highly analytical, rational, and very fairminded individual. You spend a great deal of time analyzing your own behavior to make sure it is above criticism. People with your profile often grew up in environments where a parent figure was unpredictably critical and judgmental. They had high standards and, being sensitive, criticism and judgment would make you feel guilty and ashamed. You responded adaptively by going overboard to make sure you did everything possible to avoid judgment. Now you analyze all situations to make sure that you are above criticism and have attended to your duties and responsibilities in ways that leave you beyond reproach. You may spend a great deal of time thinking about and analyzing what others think of you, what you have done in the past, and whether it leaves you open to others criticizing or judging you. It may be hard for you

to make decisions, because you see every side of an issue. It may also be hard for you to tell people how you are feeling without first explaining why your feelings are reasonable and justified. When you do that, others respond to what they see as your defensiveness by being argumentative. You may experience conflicts in which you're trying to explain the righteousness of your thoughts, feelings, desires, and behaviors. Others may become defensive and focus on some minor detail of what you have said, trying to prove you wrong. Learn to express your wants, hurts, and resentments directly without explaining why your feelings are justified or why the other person is "wrong." Try to avoid using judgmental terms when you are angry with someone. Talk about your anger using "I" statements rather than "You" statements. Remember that you are sensitive and not everybody is equally sensitive. Sometimes you may take things personally when others have been clumsy or blind to your feelings, but did not intend to be mean or cruel. Talk to your therapist if you have concerns about trusting that you can open up and disclose in the therapy session. Using CBT, work on switching off your self-critical, anxious, and guilty thoughts.

678 Code

This pattern may indicate a poor prognosis for vocational success (Harmon & Weiner. 1945).

Male

Low 0 Introverted or self-conscious or socially insecure, one interview only, nonresponsive or nonverbal, tense, indecisive, lacks knowledge or information, vague goals, confused, aggressive or belligerent.

- Note: Scale 0 coded low was infrequently associated with introversion or self-consciousness or social insecurity, being nonresponsive or nonverbal, indecisiveness.

Low 1/2/3/4/5/9 Introverted or self-conscious or socially insecure, nonresponsive or nonverbal, tense, indecisive, lacks knowledge or information, vague goals, confused.

Nothing Low Introverted or self-conscious or socially insecure, lacks skills with the opposite sex, mother conflict, sibling conflict, nonresponsive or nonverbal, tense, indecisive, unhappy, worries a great deal, insomnia, lacks knowledge or information, vague goals, confused.

Female

Low 0 Insomnia, nervous, lacks self-confidence, 8+ conferences, resistant in the interview, verbal, socially extroverted.

- Note: Scale coded low was infrequently associated with lack of self-confidence.

Low 1 Insomnia, nervous, lacks self-confidence, 8+ conferences.

Low 2 Insomnia, nervous, lacks self-confidence, 8+ conferences, socially extroverted.

- Note: Scale 2 coded low was infrequently associated with lack of self-confidence.

Low 3 Insomnia, nervous, lacks self-confidence, 8+ conferences, cried in the interview.

Low 4 Insomnia, nervous, lacks self-confidence, 8+ conferences, shy in the interview.

Low 5 Insomnia, nervous, headaches, exhaustion, anxieties, lacks self-confidence, physical inferiority, indecisive, 8+ conferences, socially insecure, distractible in study.

Low 9 Insomnia, nervous, lacks self-confidence, 8+ conferences.

Nothing Low Insomnia, nervous, restless, headaches, depressed, exhaustion, lacks self-confidence, 8+ conferences, father conflict, mother conflict, sibling conflict, lacks skills with the opposite sex.

(Drake & Oetting, 1959)

6789 Code

This pattern may suggest behavioral difficulties, especially among college freshmen women (Osborne, Sander, & Young, 1956). These women tend to approach problems with animation, are sensitive, and feel that they are unduly controlled, limited, and mistreated.

679 Code

Male

Low 0 Home conflict, one interview only, lacks knowledge or information, aggressive or belligerent, defensive. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, shyness in the interview, being nonresponsive or nonverbal, being nonverbal or a nonrelator, indecisiveness.

Low 1 Home conflict, defensive, nonresponsive or nonverbal.

Low 2/3/4/5/8 Home conflict, defensive.

Nothing Low Lacks skills with the opposite sex, home conflict, mother conflict, sibling conflict, nonresponsive or nonverbal, tense, indecisive, unhappy, worries a great deal, insomnia, confused, defensive.

- Note: Scale 9 coded high was infrequently associated with being nonresponsive or nonverbal, indecisiveness, worrying a great deal, lack of skills with the opposite sex.

Female

Low 0 Nervous, exhaustion, confused, distractible in study, marriage oriented, sibling conflict, resistant in the interview, verbal, socially extroverted.

- Note: Scale coded low was infrequently associated with exhaustion, confusion, sibling conflict.

Low 1 Nervous, confused, distractible in study, vague goals, sibling conflict, socially extroverted.

- Note: Scale 1 coded low was infrequently associated with sibling conflict.

Low 2 Nervous, confused, distractible in study, sibling conflict, socially extroverted.

- Note: Scale 2 coded low was infrequently associated with confusion.

Low 3 Nervous, confused, distractible in study, vague goals, sibling conflict, cried in the interview.

Low 4 Nervous, confused, distractible in study, sibling conflict, nonresponsive, shy in the interview.

- Note: Scale 9 coded high was infrequently associated with shyness in the interview.

Low 5 Nervous, headaches, insomnia, exhaustion, anxieties, confused, distractible in study, sibling conflict, verbal, socially insecure, lacks self-confidence, physical inferiority, indecisive.

Low 8 Nervous, confused, distractible in study, sibling conflict.

Nothing Low Nervous, restless, headaches, confused, distractible in study, sibling conflict, 8+ conferences.

(Drake & Oetting, 1959)

Code-Type 6-8/8-6

Descriptors

Complaints

Cognitive and behavioral disorganization, diffuse anxiety, paranoia, psychotic thought processes, depression, apathy, anhedonia, paranoid delusions, irritability, social withdrawal, conduct or behavior problems, somatic complaints, bizarre preoccupations, alienated, hostile, feeling misunderstood or mistreated, anger problems, socially isolated

Thoughts

Disorganized; schizoid; unconventional; circumstantial; tangential; confused; autistic; bizarre preoccupations; ideas of persecution and reference; suspicious; hallucinations or delusions; difficulties with concentration and memory; poor judgment; daydreaming; sexual, violent, or religious preoccupations; obsessive-compulsive; probable thought disorder; suicidal ideation

Emotions

Fearful, apathetic, inferiority, depression, resentment, inappropriate emotional responses, possibly phobic, moody, immature, low frustration tolerance, feeling worthless

Traits and Behaviors

Schizoid, paranoid, withdrawn, poor social skills, bizarre and eccentric behaviors, lacking in

(Levak, Siegel, Nichols, & Stolberg, 2011)

Therapist's Notes

Clients with 6-8 code types in the normal range are sensitive, creative, cautious, and vulnerable to interpersonal misunderstandings. They are thin-skinned and vulnerable to feeling humiliated or criticized, so they keep others

at a distance. When stressed they can become confused and reveal a brittle anger. Immaturity, difficulties with emotional closeness, subtle paranoid traits, and abrupt, angry reactions characterize this profile if Scale 8 elevations are not due to significant additions of Correction (K).

Elevated profiles reflect symptoms of paranoia with delusions, suspiciousness, and in some cases a schizophrenic thought disturbance. Hallucinations, both auditory and visual, are possible. Confused and unable to solve problems effectively, many individuals with this code type live a marginal existence. Although Graham et al. (1999) did not find psychosis among their 6-8 code type sample, this may have been because their study agency referred out many of their psychotic patients to other agencies. Earlier findings from both Marks and Seeman (1963) and Gilberstadt and Duker (1965) found that this code type often indicates a psychotic thought process. Even when individuals with this code type are not psychotic, they can be characterized by inappropriate and immature behavior, difficulties with memory and concentration, suspiciousness, unjustified jealousies, and unreasonable anger. Even when Scale 0 is not elevated, alienation, social withdrawal, flat, blunted, and at times inappropriate affect are common. People with this profile are often confused and persistently vigilant for anything that can be perceived as rejection or hostility. They feel isolated in a frightening world, and they have difficulty accurately perceiving others' reactions to them. These clients feel unable to control their cognitive and emotional processes. Bizarre, loose associations, surges of inappropriate emotions, and inability to comprehend others responses to them make basic tasks of life arduous if not impossible. Diffuse anxiety, a sense that the world is fragile, and a relentless, inchoate sense of dread are pervasive. These individuals often appear depressed, flat, and apathetic. Severely damaged self-esteem is reflected in the tendency for 6-8 individuals to give many "minus Rorschach" responses such as, "I see cancerous lungs ... a bleeding vagina" (Exner, 2003). Perhaps in an attempt to control internal disorganization, to bind anxiety, and to provide boundaries to their paranoid vigilance, individuals with 6-8 code types can develop superstitions, food fads, odd collections, and eccentric rituals. They have difficulties with any kind of intimacy, lack the ability to organize, and often withdraw into fantasy. Their anger is expressed in brief, acute outbursts and may come about as the result of a buildup of perceived hostility or disrespect from others. Although apathetic and withdrawn, they may show acute, dangerous assaultive behavior. It has been noted that a number of males with this profile are weapon collectors, perhaps reflecting their paranoid self-protectiveness (Friedman, Levak, Nichols, & Webb, 2001). Their existential experience is to feel under siege confused, so abrupt, unprovoked rages are not uncommon. Threats of violence and suicidal ideation should be taken seriously.

Lifestyle and Family Background

Our hypothesis is that this code type reflects a genetic predisposition and a catastrophic childhood. Experiences of will-breaking hostility and humiliation, neglect, cruelty, and mental illness in caretakers would be typical. As

children, many were fearful and insecure, perhaps exhibiting personal eccentricities or slowness to mature, making them vulnerable to ridicule and bullying. Histories tend to be characterized by family disruptions, economic hardship, and parental rejection or at best indifference. These individuals have poor work histories and a generally marginal adjustment.

(Levak, Siegel, Nichols, & Stolberg, 2011)

For both adolescents and adults, the 68/86 codetype predicts serious psychopathology and is most likely to be diagnosed with a thought disorder. It is usually accompanied by elevations on *F*, *BIZ*, *PSYC*, and *PaI*, reflecting the psychological disorganization represented by this codetype. The *F* elevation reflects the paranoid ideation, unusual experiences, cognitive, emotional disorganization, and sense of disintegration endorsed by the individual.

Psychopathology is more extreme when Scales 6 and 8 are both above *T*-65, and both are at least 10 *T*-scores above Scale 7 (sometimes called a “paranoid valley” due to the shape of the profile). A diagnosis of paranoid schizophrenia should be considered whenever the “paranoid valley” is present, and individuals with this configuration are likely to have had prior psychiatric hospitalizations, with recurrent episodes of psychosis. Since elevations on Scales 6 and 8 would suggest a severe disturbance, the lack of elevation on Scale 7, and the associated lack of anxiety would predict that the disturbance is ego-syntonic and, therefore, more resistant to treatment.

These individuals experience psychotic disorganization, mental confusion, and a constant state of alertness to being attacked, judged, and criticized, which, for most people, would be highly anxiety-provoking. In the absence of such anxiety (low Scale 7), the individual appears to have habituated to a serious, disorganizing mental illness.

68/86 individuals in general are highly suspicious, distrustful, and tend to be loners. They are suspicious of others' motives and are easily cognitively disorganized by stress. They are described as moody, hostile, unpredictable, negativistic and, at times, emotionally inappropriate. They keep others at an emotional distance because of their irritability and anger and their tendency to arouse, fear, dislike, or disgust toward them in others. Affect is typically blunted, if not inappropriate. They manifest a depressed mood with apathy and anhedonia. Although they experience feelings of profound inadequacy and inferiority, they may mask it with a brittle hostility toward others. They can quickly become preoccupied with protecting themselves against real and imaginary enemies, and may avidly collect guns, knives, or other weapons. Many of these individuals are either an only child or the youngest in the family. Some may be diagnosed as bipolar because of the abruptness of their emotional reactions and sudden brittle, angry responses. (Look for elevations on Scale 9 and low scores on Scale 0 in these cases; see 698/968 codes.) Typically these mood swings are precipitated by the perception that others are threatening them. Some can become unpredictably assaultive. Many come across as eccentric or odd, with flamboyant or frightening dress and manner, perhaps because of cognitive disorganization, social alienation, and fears of emotional closeness. Tattoos, body

piercing, and the brandishing of weapons may serve to keep others at a distance and remind them that the 68/86 individual is capable of self-defense. They are extremely sensitive to anything that can be construed as rejection or disrespect. Preoccupied with self-protection, they have little psychological insight. These individuals' thought processes are characterized by overgeneralizations, misinterpretations, tangentiality/circumstantiality, and frank delusions. They have difficulties concentrating and being productive, in part because of poor reality testing and mental confusion. Depression, odd fears, phobias, and obsessions can also be present. Inner conflicts about sexuality and feelings of sexual inadequacy are a problem for these individuals. Most adults with this codetype are single and spend a great deal of time daydreaming and fantasizing. Behaviorally, these people are unpredictable, especially if Scale 4 (see 468/648 codes) or Scale 9 (see 698/968 codes) is also elevated. Some adults with this profile reveal a history of spotty employment marked by episodic, impulsive terminations. They have difficulty controlling their anger. They exhibit episodes of fatigue, inefficiency, and difficulties with concentration. Adolescents with this codetype often show violent tempers, particularly if K is below $T-50$, and they have poor peer relations. They spend a great deal of time in fantasy and, not surprisingly, do poorly academically. Sometimes they are diagnosed with attention deficit disorder (ADD) and prescribed amphetamines with negative results. These teenagers often reveal a family history of having been subjected to corporal punishment and shaming. The 68/86 individual typically has had caregivers who were rejecting, hostile or, at best, indifferent. They are particularly sensitive to hostility, perhaps because they experienced it as children, and can respond with acute outbursts of rage if they perceive themselves to be threatened.

Guthrie described the group of medical patients with this profile pattern as prepsychotic with schizoid personality patterns. They were, however, making a marginal adjustment without hospitalization; physical complaints and preoccupation with health may have served to stabilize their precarious adjustment. They presented a wide variety of complaints which shifted from visit to visit. They also had many food fads and depended upon patent treatments and medicines. Their relationships with others were unstable and characterized by resentment. In the psychiatric population that they studied, Hathaway and Meehl (1951b) found the 68 group largely composed of psychotics, the majority being frankly schizophrenic, with a smaller portion in paranoid states. The most common feature of the behavior of these patients was the presence of paranoid delusions, but many of them also showed depression, apathy, irritability, and social withdrawal. Although they had conduct or behavior problems, their difficulties were not the classic scrapes of the amoral, asocial psychopathic group. The few neurotics seen in a psychiatric setting with this pattern were not of the somatic sort, but could be better characterized as dysphoric. Information on the 68 pattern is also reported by Marks and Seeman in their 86-68 code type.

(Dahlstrom, Welsh, & Dahlstrom, 1979)

- o Intense feelings of inferiority and insecurity; lacks self---confidence and self---esteem; feels guilty about perceived failures; withdrawal from activity; emotional apathy; suicidal ideation; not involved with other people; suspicious and distrustful; avoids deep emotional Les; deficient in social skills; most comfortable when alone; resents demands placed on him/her; moody, irritable, unfriendly, negativistic; schizoid life---style
- o Usually diagnosed as schizophrenia, paranoid type (especially if both scales are very elevated and higher than Scale 7); clearly psychotic behavior may be present; thinking is autistic, fragmented, tangential, and circumstantial; bizarre thought content; difficulties in concentrating, attending, memory; poor judgment; delusions of persecution and/or grandeur; feelings of unreality; preoccupied with abstract or theoretical matters to exclusion of specific aspects of life situation; blunted affect; rapid and incoherent speech; lacks effective defenses; reacts to stress and pressure by withdrawing into fantasy and daydreaming; may have difficulty differentiating between fantasy and reality

Individuals with this high point pair usually show evidence of a formal thought disorder and paranoid ideation compatible with a paranoid schizophrenic reaction (especially if F is greater than or equal to 70). They can be expected to suffer from moderate psychological distress, to be pervasively hostile and suspicious, and to experience delusions of persecution and/or grandeur and hallucinations. Regression, disorganization, and autistic associations are likely. Clients with this high point pair are often preoccupied with abstract or theoretical matters to the exclusion of specific concrete aspects of their lives. General apathy may be pronounced, affect seems blunted, and established defenses are lacking. Under stress, they are likely to withdraw and occupy themselves with secretive autistic fantasy accompanied by loss of capacity to recognize reality. Individuals with this high point pair are quite resentful of demands imposed on them and are described as moody, irritable, unfriendly, and negativistic. Conflicts regarding sexuality are evident. When individuals with this high point pair do not meet the traditional MMPI-2 criteria for schizophrenia, then the most likely diagnosis involves a paranoid psychosis or schizoid personality. Psychotropic medications are usually the treatment of choice for individuals with this high point pair.

Symptoms and Behaviors

The key features of people with the 68/86 code type are suspiciousness and distrustfulness, and they often perceive the intentions of others as suspect and questionable. They will be extremely distant from others, with few or no friends. They can be described as inhibited, shy, resentful, anxious, and unable to accept or appropriately respond to the demands that are made of them. As a result, they are highly involved in their fantasy world, uncooperative, and apathetic; and they have poor judgment and experience difficulty concentrating. Their sense of reality is poor, and they often experience guilt, inferiority, and mental confusion; sometimes their affect will be flat. The content of their

thoughts can be expected to be unusual if not bizarre, frequently containing delusions of grandeur and/or self-reference. While their affect might be blunt, they are still internally quite anxious. Surprisingly, their past work history is often adequate provided the elevations on 6 and 8 are not extremely high. However, an intensification of their symptoms brought on by stress will usually disrupt their ability to work. Persons with this code are more often single and younger than 26 years of age. If they are married, their spouses are frequently also emotionally disturbed. The most frequent diagnosis is paranoid schizophrenia, especially if Scale 4 is also elevated and 8 is relatively higher than 7. These persons will experience depression, inappropriate affect, phobias, and paranoid delusions. If Scale 7 is 10 points or more lower than Scales 6 and 8, this pattern is called the “paranoid valley” and emphasizes the presence of paranoid ideation. A highly elevated *F* with Scales 6 and 8 above 80 does not necessarily indicate an invalid profile. A paranoid state is also a frequent diagnosis with the 68/86 code; less frequently, organic brain disorders or severe anxiety disorders may be diagnosed.

Personality and Interpersonal Characteristics

Persons with this code type will be insecure with low self-confidence and poor self-esteem. Others perceive them as being unfriendly, negativistic, moody, and irritable. Because their level of social discomfort is high, they will feel most relaxed when alone and will generally avoid deep emotional ties. Their defenses will be poorly developed and, when under stress, are likely to regress (check the LSE/Low Self-Esteem and SOD/Social Discomfort scales).

o Pervasive but poorly differentiated distress with severe cognitive and behavioral disorganization, regression, and disability. Anxiety expressed as dread or panic. Depression expressed in apathy; anhedonia; agitation; fatigue; moodiness; sleep disturbance; attitudes of helplessness, hopelessness, and worthlessness; and suicidal ideation, rather than in manifest dysphoric mood. Affect typically blunted or inappropriate. Chronic feelings of inadequacy and inferiority. Manifest psychotic symptoms include gross thought disorder; hallucinations; pervasive but loosely structured delusional ideation (reference, persecution, control); and bizarre preoccupations; as well as moderate to severe impairment of attention, concentration, memory, and judgment. Problem solving is unconventional, inadequate, incompetent, and often autistic. Severely alienated from both interpersonal and material worlds with suspiciousness and hostility, and bland but pervasive apprehensiveness and incomprehension, respectively. May spend majority of time in fantasy and daydreaming, often with sexual, violent, religious, or supernatural preoccupations. Feels misunderstood, despised, and mistreated by others and anticipates further unfriendliness, mistreatment, and rejection. Becomes angry for no apparent reason. Quick to feel threatened and attacked and may become unpredictably assaultive. Viewed by others as odd, peculiar, eccentric, or weird in dress and manner, and

interpersonally withdrawn. May use bizarreness to keep others at a distance, but feels lonely and isolated. Fears being seen as awkward and inept; easily embarrassed and humiliated. Disorganized by rejection. Severe lack of insight. Look for a history of parental neglect/rejection/cruelty, bullying by peers, poor achievement, social isolation (never married [men]), spotty employment, prior hospitalizations, and substance abuse.

6-8/8-6

Patients with this profile type usually experience severe mental disorder and are diagnosed as having schizophrenia, paranoid type. They manifest clearly psychotic behavior; their thinking is autistic, fragmented, tangential, and circumstantial. They usually experience bizarre thought content and have difficulties in concentrating, attention, and memory. They usually have poor judgment, delusions of persecution or grandeur, and feelings of unreality. They typically show a preoccupation with unusual, abstract thoughts. Delusions and blunted affect are often present. These individuals may have rapid and incoherent speech. They tend to lack effective defense mechanisms and show extreme anxiety at times. They are likely to react to stress and pressure by withdrawing into fantasy and daydreaming. They tend to have difficulty in differentiating between fantasy and reality.

Feelings of inferiority and insecurity are common in this type of patient, as is a lack self-confidence and self-esteem. People with this pattern often feel guilty about perceived failures. Social withdrawal from activity and emotional apathy are likely to be prominent in their clinical pattern. These patients are usually not involved with other people and are suspicious and distrustful, usually avoiding deep emotional ties. Their poor social skills are likely to limit efforts at rehabilitation. They are most comfortable when they are alone. They resent interpersonal demands placed on them, and they become moody, irritable, unfriendly, and negative. They tend to have a long-term pattern of maladjustment and usually a schizoid life style. They are typically treated with phenothiazines to control their psychotic thought patterns and behaviors.

68/86

Persons with the 68/86 code type harbor intense feelings of inferiority and insecurity. They lack self-confidence and self-esteem, and they feel guilty about perceived failures. Withdrawal from everyday activities and emotion. il apathy are common, and suicidal ideation may be present. 68/86 persons are not emotionally involved with other people. They are suspicious and distrustful of others, and they avoid deep emotional ties. They are seriously deficient in social skills, and they are most comfortable when alone. They are quite resentful of demands placed on them, and other people see them as moody, irritable, unfriendly, and negativistic. In general, their lifestyles can be characterized as schizoid.

Although some persons with the 68/86 code type are diagnosed as having paranoid or schizoid personality disorders, among psychiatric patients this configuration usually is associated with a diagnosis of schizophrenia, paranoid type, particularly if scales 6 and 8 are considerably higher than scale 7.

68/86 individuals are likely to manifest clearly psychotic behavior. Thinking is described as autistic, fragmented, tangential, and circumstantial, and thought content is likely to be bizarre. Difficulties in concentrating and attending, deficits in memory, and poor judgment are common. Delusions of persecution and/or grandeur and hallucinations may be present, and feelings of unreality may be reported. Persons with the 68/86 code type often are preoccupied with abstract or theoretical matters to the exclusion of specific, concrete aspects of their life situations. Affect may be blunted, and speech may be rapid and at times incoherent. Effective defenses seem to be lacking, and these persons respond to stress and pressure by withdrawing into fantasy and daydreaming. Often it is difficult for 68/86 persons to differentiate between fantasy and reality. Medical consultation to determine appropriateness of psychotropic medication should be considered.

6-8 See also the 8-6 combination, p. 209.

1. These people could have marginal psychological adjustment (Hovey & Lewis, 1967).
2. These people tend to have intense feelings of inferiority and insecurity. They are suspicious and distrustful of others and avoid deep emotional ties (Graham, 1977).
3. Relationships with others tend to be unstable and characterized by resentment (Dahlstrom & Welsh, 1960).
4. They may present a wide variety of complaints which shift from one time to the next (Dahlstrom & Welsh, 1960).
5. They tend to be drawn towards fads and quacks (Dahlstrom et al., 1972).
6. If these people can get verbally angry with the therapist, they tend to get better rapidly (Caldwell, 1974).
7. One study (Lewandowski & Graham, 1972) has found that patients with the 64 pattern have spent more time in a neuropsychiatric hospital than other patients. They tended to be unfriendly with others; to have

less social interests; to be more emotionally withdrawn, conceptually disorganized, and suspicious; and to have more hallucinatory behavior and unusual thought content.

8. Another study reported in two references (Altman, Gynther, Warbin, & Sletten, 1972; Gynther et al., 1973) has found patients in a mental hospital with this 6-8/8-6 pattern often seem unfriendly and angry for no apparent reason. They also have thought disorders, hallucinations, delusions, hostility, and lack of insight. Poor judgment was typical. Of those patients labeled psychotic, schizophrenia was the most frequent diagnosis, especially paranoid schizophrenia. For the 64 profile, the delusions are apt to be delusions of grandeur. - For the 8-6 profile, the affect is apt to be blunted.
9. Marks et al. (1974) found the 8-6/6-8 pattern in a university hospital and outpatient clinic. They found this pattern primarily for females who were having unconventional, delusional thoughts. These women were also suspicious. The Marks, Seeman, and Haller book should be consulted for further information concerning this profile.
10. Black psychiatric patients show this configuration significantly more than white psychiatric patients matched on age, sex, hospital status, socioeconomic status, and duration of illness (Costello & Tiffany, 1972).
11. VA hospital males with this pattern tended to be ruminative and thinking in unusual ways. They may have had paranoid thinking verging on the delusional. They had precarious psychological and emotional adjustment and tended to be pre-psychotic (Hovey & Lewis, 1967).
12. Adolescents in treatment with the 64/8-6 pattern (Marks et al., 1974) were referred because of bizarre behavior. They had violent tempers and tended to be below average intellectually. They frequently used drugs. The Marks, Seeman, and Haller book should be consulted for further information concerning this profile.
13. For college students with this pattern, men tended to be indecisive, unhappy, and confused; women were restless, depressed, and had conflicts with parents and siblings. They also lacked skills with the opposite sex (Drake & Oetting, 1959).

Description:

Rebellion, anger, fear of persecution, aggressive acting out, pre- or psychotic adjustment, underlying inferiority, fearfulness, low self-esteem, emotionally unstable

Possible Diagnoses:

Substance abuse, Paranoid schizophrenia, Brain damage, Borderline, Schizoaffective, Psychopathy, Antisocial p.d.

Modifying Scales

- An “all true” response set produces a highly elevated 6-8 code type.
- High Infrequency (F), Back Infrequency (Fb), and Infrequency Psychopathology (Fp) scores are commonly associated with 6-8 code types.
- Typically, Scale 2 and Depression (DEP) will be elevated given the despondency state and lack of positive experiences associated with this code-type.
- If Scale 4 is elevated, especially if Pd2 and Antisocial Practices (ASP) or Antisocial Behavior (Rc4) are also elevated, look for the possibility of bizarre antisocial acting-out behavior.
- A marked elevation on Ideals of External Influence (Pa1) or Persecutory Ideas (RC 6) would predict a floridly paranoid disturbance.
- If Psychomotor Acceleration (Ma2) is elevated, this would tend to energize and agitate the manifestation of a thought disorder.
- An elevation on Ego Inflation (Ma4) would reflect individuals who believe they have special powers and a special mission in the world.
- In the presence of a high MacAndrew Alcoholism Scale-Revised (MAC-R) (over a raw score of 27), the use of chemical agents may aggravate the severity of the psychotic disturbance.
- Elevations on Anger (ANG) and Aggressiveness (AGGR) predict brittle, bizarre, and dangerous expressions of anger.
- If either Bizarre Mentation (BIZ), Psychoticism (PSYC), or Aberrant Experiences (RC8) is elevated, the profile reflects a psychotic disturbance.
- Typically, Work Inference (WRK) and Negative Treatment Indicators (TRT) are also elevated, reflecting the collapse of the individuals’ life and a profound distrust that anyone can help.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Male

Low 0 Lacks knowledge or information, aggressive or belligerent.

Low 9 Introverted or self-conscious or socially insecure.

Nothing Low Indecisive, unhappy, worries a great deal, insomnia, confused.

Female

Low 0 Socially extroverted, 8+ conferences, verbal, resistant in the interview.

Low 1 8+ conferences.

Low 2 8+ conferences, socially extroverted.

Low 3 8+ conferences.

Low 4 8+ conferences, shy in the interview.

Low 5 8+ conferences, physical inferiority, distractible in study, anxieties.

Low 7/9 8+ conferences.

Nothing Low 8+ conferences, restless, depressed, lacks skills with the opposite sex, father conflict, mother conflict, sibling conflict.

(Drake & Oetting, 1959)

o **Check:** *DisOrg, CogProb, RC8, RC6, ANX, FRS1, OBS, DEP1, DEP2, DEP3, DEP4, HEA1, HEA2, HEA3, BIZ1, BIZ2, LSE1, WRK, PSYC, NEGE, INTR, Dr1, Dr3, Dr4, Dr5, Hy3, Hy4, Pd4, Pd5, Pa1, Pf1, Pf2, Pf3, Pf4, Pa2, Pa3* (low), *Sc1, Sc2, Sc3, Sc4, Sc5, Sc6, A, R, AAS, MDS*.

TREATMENT

Insight therapy is contraindicated because these individuals readily become cognitively and emotionally disorganized. They may perceive the therapist as a potentially critical authority figure, possibly replicating their upbringing of having been treated coldly or cruelly. In therapy, they can easily become sidetracked and paranoid, ruminating about aggression they perceive to be directed at them by others. Psychotherapy should be nurturing and, if possible, reparenting and soothing, rather than attempting immediate behavior change. Providing structure without being overly friendly; being supportive and understanding can help the 68/86 individual feel less threatened. Antipsychotic medication is recommended. Often these individuals need assistance in meeting their basic needs, such as shelter, helping them navigate the complexities of finding employment, and managing daily affairs, such as paying bills and dealing with government agencies. Many rely on government programs for financial support. Sometimes they can become hooked in a retaliatory battle with a government employee whose rigid adherence to various bureaucratic rules appears to them as a vendetta against their rightful benefits.

o **Treatment:** Rule out Paranoid Schizophrenia; Disorganized Schizophrenia; Schizotypal Personality Disorder; Bipolar Disorder, Depressed (rare). Treatment with antipsychotic medications is most promptly and reliably (albeit incompletely) effective. Benefits from structure and support, including environmental manipulation, sheltered employment, and reliable assistance in managing daily affairs. Psychoeducational measures such as skills training, medication management, and relapse prevention are often helpful. Supportive psychotherapy is helpful in reducing sense of isolation and estrangement and in managing illness and its consequences, but requires long-term commitment. Ameliorative goals must be considered carefully because of the risk of distorted understandings secondary to autism and thought disorder. Treatments emphasizing insight tend to be stressful and disorganizing.

- Frequent diagnoses: paranoid schizophrenia (especially with high 4 and if 8 is relatively higher than 7) with depression (elevated 2), inappropriate affect, phobias, and paranoid delusions; note “paranoid valley” (when 7 is 10 points or more lower than Scales 6 and 8), which emphasizes the presence of paranoid ideation; possibly organic brain disorders. (Groth-Marnat, 2009)

Treatment Implications

Because a significant level of psychopathology is present with this profile, clinicians must be aware of a number of different issues related to further assessment and case management. In particular, treatment on either an inpatient or an outpatient basis needs to be decided. One of the major factors in this decision is a further assessment of the extent to which clients are a danger to themselves or others. A further consideration is whether psychopharmacological intervention and maintenance will help control psychotic thinking. In addition, basic daily living skills will be an issue. Clients might require training in basic social skills, assertiveness, job interviewing, and knowledge of resources to resort to when their symptoms increase. Insight-oriented therapy is often contraindicated as self-reflection might result in further regression. Instead, a concrete, behaviorally oriented method of intervention is likely to be more successful. One difficulty might be that these clients have unusual or even bizarre belief systems with quite different sets of logic than the therapist (check the BIZ/Bizarre Mentation scale). This might pose particular problems for attempts at cognitively based interventions. Furthermore, their level of suspicion and projection of blame will present further challenges. Because of their high level of mistrust, poor social skills, and social discomfort, they are likely to have difficulty forming a relationship with a therapist. Often, sessions will seem slow, unproductive, and characterized by long periods of silence. Impulsivity and regression are also likely to provide further treatment challenges.

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that currently you are feeling vulnerable to being criticized, judged, attacked, or humiliated by others. You appear to be going through life feeling unsafe, as if others are going to hurt or somehow humiliate you. You may be spending a lot of time thinking and fantasizing about who is “for” you or “against” you, and how you can protect yourself against your enemies. No wonder you do not enjoy life much of the time and feel sad, anxious, and preoccupied. Often people with your profile grew up in environments where someone was extremely critical and judgmental, or even cruel and rejecting. From an early age you learned to protect yourself, and to lash out and hurt others before they could hurt you. Perhaps one of your parents had a mental illness or some other problem that led them to be extremely strict and at times cruel, or even indifferent and uncaring. To protect yourself, you had to withdraw from others and comfort yourself by your inner world. Currently, you may be finding the world a frightening place, and it is hard for you to know whom you can trust. At times your mind might become invaded by strange and frightening thoughts, and it may be hard for you to distinguish between what is real and what is your imagination. When you are stressed, it is easy for your mind to play tricks on you, and for you to feel periods of panic and confusion about what is real and what is not. Your therapist may want to help you feel safer by suggesting medication that can take away some of the panicky feelings and confused thoughts. It is important to talk to your therapist about trust and what it will take for you to feel comfortable in therapy. Maybe you could both discuss some basic “rules of the game,” so you can feel you have some control over the therapy process. If you are currently feeling afraid of being attacked and criticized, talk to your therapist about plans to defend yourself, so that you can get help to see how serious your current fears and anxieties are, and how seriously you should take some of your perceived threats.

687/867 Codes

687/867

This code type, in which scales 6 and 8 typically are much more elevated than scale 7, has been referred to as the “psychotic valley.” It suggests very serious psychopathology, and the most common diagnosis for persons with the code type is schizophrenic disorder (paranoid type). Hallucinations, delusions, and extreme suspiciousness are common. Affect tends to be blunted. Persons with this code tend to be shy, introverted, and socially withdrawn, but they may become quite aggressive when drinking. They tend to have problems with memory and concentration. Although persons with this code type may not be experiencing disabling emotional turmoil, they often are unable to handle the responsibilities of everyday life and require inpatient treatment. Psychotropic medications often are prescribed.

o “Psychotic valley”; most common diagnosis is paranoid schizophrenia; thought disorder likely; similar to 68/86; hallucinations, delusions, suspicious; blunted affect; shy, withdrawn, introverted; aggressive when drinking; problems with memory and concentration

o Like 6-8/8-6, but with severe tension, hypervigilance, anger, and fears of loss of control. Fear and disorganization may combine with delusional ideation, leading to assault and violence against perceived enemies.

This code type, in which scales 6 and 8 typically are much more elevated than scale 7, has been referred to as the “psychotic valley.” It suggests very serious psychopathology, and the most common diagnosis for persons with the code type is schizophrenia, paranoid type. Hallucinations, delusions, and extreme suspiciousness are common. Affect tends to be blunted. Persons with this code type tend to be shy, introverted, and socially withdrawn, but they may become quite aggressive when drinking. They tend to have problems with memory and concentration. Although persons with this code type may not be experiencing disabling emotional turmoil, they often are unable to handle the responsibilities of everyday life and require inpatient treatment. Psychotropic medications often are prescribed.

Description:

Where 6&8 are >75 and 7 is <65 - “paranoid valley” - might have paranoid schizophrenia, auditory hallucinations, psychotic behavior, autistic thinking, blunted affect, rapid and incoherent speech, withdrawal into fantasy, low insight

689 Code

- This pattern may indicate a poor prognosis for vocational success (Harmon & Wiener, 1945).
- It typifies male Blacks from a rural, isolated background (Gynther et al., 1971).

Male

Low 0 Lacks knowledge or information, aggressive or belligerent, lacks academic motivation. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, shyness in the interview, being nonresponsive or nonverbal, being nonverbal or a nonrelator, indecisiveness.

Nothing Low Indecisive, unhappy, worries a great deal, insomnia, confused.

- Note: Scale 9 coded high was infrequently associated with indecisiveness and worrying a great deal.

Female

Low 0 Restless, resistant in the interview, verbal, 8+ conferences, confused, socially extroverted, marriage oriented.

- Note: Scale coded low was infrequently associated with confusion.

Low 1 Restless, resistant in the interview, verbal, 8+ conferences, confused, socially extroverted, vague goals.

Low 2 Restless, exhaustion, resistant in the interview, verbal, 8+ conferences, confused, socially extroverted.

- Note: Scale 2 coded low was infrequently associated with confusion.

Low 3 Restless, resistant in the interview, verbal, 8+ conferences, confused.

Low 4 Restless, resistant in the interview, verbal, 8+ conferences, nonresponsive, confused, shy in the interview.

- Note: Scale 9 coded high was infrequently associated with shyness in the interview.

Low 5 Restless, anxieties, exhaustion, resistant in the interview, verbal, 8+ conferences, cried in the interview, confused, physical inferiority, distractible in study.

- Note: Scale 5 coded low was infrequently associated with resistance in the interview.

Low 7 Restless, resistant in the interview, verbal, 8+ conferences, confused.

Nothing Low Restless, depressed, resistant in the interview, verbal, 8+ conferences, confused, lacks skills with the opposite sex, father conflict, mother conflict, sibling conflict.

(Drake & Oetting, 1959)

69/96 Codes

(see also 698/968 Codes)

Code-Type 6-9/9-6

Descriptors

Complaints

Manic, irritable, suspicious, impatient, resentful, brittle anger, explosive episodes, agitation, possibly psychotic with paranoia

Thoughts

Paranoid, grandiose, suspicious, rationalized resentments, hyperrational, preoccupation with criticism, fears of being judged or attacked, flight of ideas, sexually preoccupied

Emotions

Tense, irritable, impatient, moody, agitated, jealous, possessive, fears of emotional closeness, fears of intimacy

Traits/Behaviors

Manic or hypomanic, paranoid, agitated, irritable, demanding, excitable, preoccupied with fears of criticism, preoccupied with protecting against real and imagined enemies, explosive if confronted or crossed

(Levak, Siegel, Nichols, & Stolberg, 2011)

This codetype predicts paranoid grandiosity, high energy, poor impulse control, insecurity, fear of inadequacy, and a strong need for acceptance and approval. The paranoia reflects fear of being criticized and judged. For both men and women, Scale 4 or 8 is most often the third highest scale. People with this profile are tense, wound up, and quick to overreact to minor stressors, as though they were emergencies or potentially dangerous personal threats. These individuals live in a constant state of agitation and vigilance, feeling vulnerable to attack, criticism, and judgment from others. They have difficulty recognizing when they feel anger, so they are unable to express it in any modulated way. Anger tends to build up as an accumulation of resentments. The mania/hypomania energizes the paranoia, so the 69/96 individual is constantly alert and sees potential malevolence in almost every interaction. When anger is expressed, it tends to come as a breakdown of brittle control. These individuals often feel unfairly treated, persecuted, and thwarted in their goal-seeking activity. They are very sensitive to being controlled, and many experience family conflicts and in-law problems if married. They are rigidly moralistic and judgmental of others, perhaps as a defense against feeling judged. They defensively extol their virtues, which tend to be expressed in a competitive manner, as if they are defending themselves by revealing how others are inferior. Caldwell (personal communication, 2000) has described this codetype as reflecting the “left-out sibling” conditioning experience, in which the person has felt somehow not good enough relative to the other siblings. They develop a lifestyle that is hypomanically defensive, constantly seeking attention, approval, and acceptance, and at the same time judging others as if they were competitors for approval in a zero sum game. People with this codetype tend to be excitable, loud, and sometimes charismatic, although also circumstantial. Paranoid defensiveness, flight of ideas, and overt psychosis also occur. The hypomania is experienced by others as intensity, irritability, impatience, suspiciousness, and resentment. These individuals can quickly become hostile if they feel threatened or criticized. Some may experience psychotic breakdowns, with hallucinations, religious visions, and delusions of grandeur and persecution. Most of the time, however, they appear to function relatively well for periods of time. This can be diagnostically confusing because the paranoid grandiosity can sometimes have some basis in reality. These individuals tend to commit to too many tasks and activities, and can be rigid and lack flexibility about doing things their own way. Often hypersexual, they can also be extremely jealous, possessive, and some may even become violent if their emotional security feels threatened. Family history often reveals a highly protective and affectionate parent who was also a strict disciplinarian. The other parent tends to be permissive or uninvolved. Both men and women with this codetype value being seen as attractive and often can be quite seductive and dress flamboyantly. However, they fear emotional involvement because of fears of rejection and demand a great deal of affection and reassurances of loyalty. If Scales 8 and 4 are also elevated, the propensity for violence increases.

Therapist's Notes

In the normal range, 6-9 elevations suggest active, energetic, optimistic, somewhat opinionated, sensitive, and high-strung individuals. They are perfectionists who have high standards for themselves and others, are interpersonally sensitive and can become argumentative or angry if criticized. They are competitive, tend to overcommit, and have strong needs to prove themselves. The interaction of Scale 9 and Scale 6 provides an example of competing and mixed feelings. The Scale 9 grandiose impulsivity and demands for attention, affection, and approval are modified by the Scale 6 fears of judgment, criticism, and attack. Paranoid rumination and preoccupation with "who is responsible for my trouble" are energized by mania, leading to rationalized and convoluted paranoid conspiracy theories. Unlike the elevated Scale 8, where paranoid and psychotic episodes are somewhat diffuse and disorganized, the 6-9 code types' paranoia is fixed, rational, and well organized. Clients with this profile do not appear schizophrenic in the traditional withdrawn and disorganized way. Although they may experience hallucinations and delusions of grandeur, conspiracy, persecution, or religious delusions, these are more akin to paranoid and manic defenses or a mood disorder rather than manifestations of a thought disorder. Because the paranoia is organized by manic defenses, these individuals appear almost plausible and relatively coherent. Tense, irritable, angry, and abrupt reactions when confronted or criticized can almost seem justified. Cogently argued perfidy, claiming spouses that belong to child-abusing sects, and secret agreements with governmental agencies appear almost plausible. These individuals are very safety conscious, feel threatened by any loss of financial or emotional security, and are often perceived as jealous and demanding. The perception of infidelity can be a precipitating circumstance for a paranoid manic episode. If they feel slighted, criticized, or unfairly judged, their anger can express itself as a dangerous breakdown of brittle controls. Typically, they deal with stress by feeling maligned and victimized and then rationalize their needs to counterattack. They are not introspective and move into action when stressed. They are image conscious and have strong needs to be seen as sexually attractive; however, becoming emotionally close and letting down their guard is frightening because they are preoccupied with fears of judgment.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Lifestyle and Family Background

A childhood history of parental criticism and judgment in spite of high achievement is prototypic. The 6-9 code type often represents an adaptation to care-givers who continuously insisted upon greater achievement but, at the same time, disparaged the child for not doing enough. In some cases, these clients felt disfavored relative to other siblings which left them striving for acceptance and feeling that whatever they accomplished was not enough. These clients have a high degree of pride and are sensitive to any criticism from the therapist, so they will tend to rationalize their

childhoods. Early achievement is typical because of drive and ambition; however, later success may be spotty due to impulsivity and interpersonal conflicts. Our hypothesis is that the 6-9 code types have adapted to critical disapproval and high demands for success and achievement by maintaining a rigid set of values, driving themselves to achieve, and finding fault with others as a way of bolstering their status and preempting criticism.

(Levak, Siegel, Nichols, & Stolberg, 2011)

- o Very dependent; strong need for affection; vulnerable to real or imagined threat; feels anxious much of the time; may be tearful and trembly; overreacts to minor stress; responds to severe stress by withdrawing into fantasy; can't express emotions in adaptive, modulated way; may alternate between overcontrol and direct, uncontrolled emotional outbursts

- o Psychiatric patients with this code usually diagnosed as schizophrenia, paranoid type; likely to show signs of thought disorder; complains of difficulties in thinking and concentrating; stream of thought retarded; ruminative, overrideational, obsessional; may have delusions and hallucinations; speech may be irrelevant and incoherent; disoriented and perplexed, poor judgment

Individuals with this high point pair are tense, anxious, and usually react to even minor obstacles and frustrations with irritability, jumpiness, and ineffective excitability. They respond to environmental stimuli in an emotional way and have difficulty with thinking and concentration. Grandiosity is a prominent feature and disorientation, feelings of perplexity, and confusion are noted. They suffer from ideas of reference and a pervading suspiciousness, which at times may take the form of paranoid mentation and even delusions. Individuals with this high point pair tend to ruminate and obsess but rarely translate their ideas into constructive behaviors. Also evident is considerable difficulty externalizing their obvious anger and hostility in socially acceptable ways. Periodic undercontrolled emotional outbursts will alternate with excessive restraint and control. In Scales F and 8 are also elevated, then a schizophrenic disorder is a possibility. Otherwise, some type of manic disorder, acute psychotic episode, or drug-induced psychosis should be considered. Medications appear to be the treatment of choice for individuals with this high point pair.

Symptoms and Behaviors

Persons with 69/96 profiles are likely to be excited, oversensitive, mistrustful, energetic, and irritable. They may have difficulty thinking and exercise poor judgment. They feel extremely vulnerable to real or imagined threats and

experience anxiety much of the time. Their typical response to stress is to withdraw into fantasy. They may have clear or subtle signs of a thought disorder including delusions, difficulty concentrating, hallucinations, tangential associations, incoherent speech, and appear perplexed and disoriented. They are likely to be obsessional, ruminative, and overideational. Diagnosis is likely to be either schizophrenia (paranoid type) or a mood disorder.

Personality and Interpersonal Characteristics

Individuals with this profile can be described as mistrustful and suspicious. They also have high needs for affection, and their relationships will often be passive-dependent. There is likely to be a clear discrepancy between how they describe themselves and how others perceive them. Whereas they describe themselves as calm, easygoing, happy, and in good health, others are likely to describe them as hostile, angry, and overreactive to even minor stress. These reactions to stress can result in their either becoming overly excited or apathetic and withdrawn. Thus, they have difficulties modulating their expression of emotions.

o Inflated, excited, loud, and circumstantial, grandiose, and possibly euphoric, but also tense, irritable, impatient, suspicious, and resentful. Emotional and especially behavioral controls are impaired and unstable. Speech is overproductive and may show flight of ideas. Quick to become restless, agitated, overreactive, and hostile when feeling frustrated, threatened, criticized, or dominated. Shows multiple psychotic signs and symptoms including hallucinations; delusions of grandeur, persecution, conspiracy, reference, or control; and hyperreligiosity, or religious delusions; but may show only minimal thought disorder. Most basic cognitive functions are intact except when aroused by threat, but judgment is impaired by delusional ideation, and problem solving is inflexible and stereotyped. Fears being controlled by others. Hypervigilant for criticism or attack. Spends much time in fantasy and daydreaming, and in ruminating on themes of persecution, mistreatment, vengeance, jealousy, and sexuality. Tense, rigid, and brittle; loss of behavioral control may result in violent acting out. Judges others harshly. Has strong needs for affection, loyalty, and to be sided with, but hyperrationality, suspiciousness, fear of emotional involvement, and lack of warmth keep others at a distance. Look for a history of prior hospitalization, substance abuse, and homicidal ideation.

1. This is not a common profile pattern; however when present, it may indicate paranoid grandiosity (Lachar, 1974).
2. These people tend to be angry, rational, and insistent about why they do things. They tend to give much moral justification for whatever they do (Caldwell, 1972).

3. They have difficulty with criticism, therefore they use projection frequently as a defense mechanism (Caldwell, 1972).
4. They are vulnerable to threat and feel anxious and tense much of the time. They may alternate between overcontrol and emotional outbursts (Graham, 1977).
5. VA hospitalized men with this pattern tended to be tense and overreact to possible danger. They seemed to be unable to express their emotions in an adaptive way (Hovey & Lewis, 1967).
6. Marks et al. (1974) found the 9-6/6-9 pattern in a university hospital and outpatient clinic. It was found primarily for females who were agitated, tense, excitable, suspiciousness, and hostile. The Marks, Seeman, and Haller book should be consulted for further information concerning this profile.
7. In another study reported in two references, Gynther et al. (1973d) and Gynther (1973) found patients with this code type 6-9, 9-6 to be excited, hostile, loud, and grandiose, with little likelihood of having depressive symptoms.
8. For college students with this pattern, men tended to be aggressive or belligerent, especially if the 0 scale was low. Women were restless (Drake & Oetting, 1967).

6-9/9-6

These patients are likely to be overly sensitive and mistrustful. They may show a strong need for affection, feel vulnerable to real or imagined threats, and feel anxious much of the time. They may be tearful and trembling, overreact to minor stress, respond to severe stress by withdrawing into fantasy, and cannot express emotions in adaptive, modulated way. They may alternate between overcontrolled and direct, uncontrolled emotional outbursts.

Psychiatric inpatients with this code may be diagnosed as schizophrenia, paranoid type, or a mood disorder. They are likely to show signs of thought disorder and complain of difficulties in thinking and concentrating. They appear to have stream of consciousness problems and are ruminative or overideational and obsessional. They may have delusions and hallucinations, and their speech may be irrelevant and incoherent. They often are disoriented and perplexed and have poor judgment.

69/96 individuals are rather dependent and have strong needs for affection. They are vulnerable to real or imagined threat, and they feel anxious and tense much of the time. In addition, they may appear to be tearful and trembling. A marked overreaction to minor stress also is characteristic of persons with the 69/96 code type. A typical response to severe stress is withdrawal into fantasy. 69/96 individuals are unable to express emotions in an adaptive, modulated way, and they may alternate between overcontrol and direct, undercontrolled emotional outbursts.

Psychiatric patients with the 69/96 code type frequently receive a diagnosis of schizophrenia, paranoid type, and they are likely to show signs of a thought disorder. They complain of difficulties in thinking and concentrating, and their stream of thought is retarded. They are ruminative, overideational, and obsessional. They may have delusions and hallucinations, and their speech seems to be irrelevant and incoherent. They appear to be disoriented and perplexed, and they may show poor judgment.

Description

Hostile, angry, excitable, counterphobic response to strong dependency needs and insecurity, overresponsive to emotional slights

Possible Diagnoses:

Brain damage, Manic episode, Bipolar, Dysthymic, Paranoid schizophrenia

Modifying Scales

- When Scale 2 is elevated, rule out an agitated depression or bipolar disorder. The 6-9 code types with elevated Scale 2 may be reflecting a manic phase of a bipolar disorder. These individuals can be moody, irritable, and explosive and might manifest brief paranoid episodes.
- When Scale 5 is elevated in males, look for preoccupations with sexual identity, sexuality, and sexual rejection. If scale 5 is elevated in females, this would increase the likelihood of acting-out behavior, even if Scale 4 is not particularly elevated. Scale 5 in the masculine direction for both males and females potentiates acting-out behavior.
- When Scale 4 is elevated, look for impulsive, vindictive, angry, and dangerous outbursts.
- When Overcontrolled Hostility (OH) is above a raw score of 18, explosive episodes would be more likely, and these would be potentially dangerous.
- When Correction (K) is elevated along with Scale 4, look for vindictive, well-organized, and potentially dangerous Machiavellian individuals.
- When Ideas of External Influence (Pa1) is elevated, this suggests a paranoid disorder.

- When Poignancy (Pa2) is elevated, there may be increased sensitivity that shades toward feelings of being mistreated, misunderstood, and the storing of rationalized resentments.
- Naïveté (Pa3) elevations, reflect the 6-9 code types' tendency to have rigid values and morals, perhaps as a defense against being criticized or judged.
- When Anger (ANG) or Hypomanic Activation (RC9) are elevated, problems with anger and explosive irritability may be recurrent and possibly dangerous. If Antisocial Practices (ASP) and Scale 4 are elevated, the profile could reflect paranoia and sociopathic acting out. If Scale 4 is not elevated above a T-score of 60 but Authority Conflict (Pd2) is, the likelihood of Machiavellian acting out increases.
- When Type A Behavior (TPA) is elevated, are supported intense, competitive drive and needs to be above criticism.
- When Bizarre Mentation (BIZ), Aberrant Experiences (RC8), Psychoticism (PSYC), or Ideas of Persecution (RC6) is elevated, the possibility of a paranoid psychotic reaction increases.
(Levak, Siegel, Nichols, & Stolberg, 2011)

Male

Low 0 Aggressive or belligerent. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, shyness in the interview, being nonresponsive or nonverbal, being nonverbal or a nonrelator, indecisiveness.

Female

Low 0 Resistant in the interview, verbal, marriage oriented, socially extroverted.

Low 1 Vague goals, socially extroverted.

Low 2 Socially extroverted.

Low 3 Vague goals.

Low 4 Shy in the interview, nonresponsive.

- Note: Scale 9 coded high was infrequently associated with shyness in the interview.

Low 5 Exhaustion, verbal, physical inferiority.

Nothing Low Restless, 8+ conferences.

(Drake & Oetting, 1959)

o **Check:** *ANX, BIZ1, BIZ2, CYN2, SOD1* (low), *SOD2* (low), *AGGR, PSYC, DISC, RC9, RC6, Dr2* (low), *Hy2* (low), *Hy5* (low), *Pd4, Pa1, Pf1, Pf2, Pf3, Pf4, Pa2, Pa3, Pf1, Pf2, Pf3, Pf4, Sc1, Sc3, Sc5, Sc6, Ma1, Ma2, Ma3, Ma4, Si1* (low), *Si2* (low), *A, R, Re, MAC-R, AAS, MDS*.

TREATMENT

These individuals are defensive, seeing interactions as arguments in which they have to argue, explain, and rationalize their own behavior. Therapists may become defensive, since these patients will tend to judge and define the therapist's behavior, perhaps as a defense against being judged themselves. Even if *MAC-R* is not elevated, many have chemical addiction issues. They tend to be guarded and want to remain in control of their emotions, so articulating how they feel can be threatening to them. In some cases, a mood stabilizer can decrease the level of paranoia. Many are quite resistant to the sedating effects of antipsychotic and anti-manic agents. Therapists are most effective if they are willing to give the 69/96 individual approval and spend time listening to their elaborate hypomanic ambitions; initially taking the role of a coach rather than a therapist works best, since it avoids the stigma of a mental illness diagnosis.

Look for childhood histories of a strict, controlling, caring, but also critical, parent. Help the patient explore any memories of parent figures being harshly critical and shaming. Without criticizing the judgmental parent, help the patient experience how those moments of being criticized were particularly painful and may have felt unfair. Help them understand how their drive to be perfect and above criticism makes sense given how much they wanted to please and avoid criticism, but were, nevertheless, subjected to it. Their high drive and argumentative defensiveness makes adaptive sense given their parents' high standards and shaming criticisms. Explore how currently they may be feeling vulnerable to criticism or disapproval from others. Usually a precipitating circumstance for the increased hypomania and/or paranoia is a perceived rejection that is experienced as traumatic. If medication is indicated, help manage resistance by explaining how it could help them problem solve more efficiently. Help them distinguish between real threats and their hypervigilance.

When slighted or feeling wronged, these individuals can be dangerous, especially if they verbalize threats. It is important that the therapist does not become defensive if the patient reports feeling criticized by the therapist or becomes critical of the therapist. Genuine concern for the patient's hurt feelings as well as helping them engage in situations in which they felt particularly emotionally wounded can be productive if the therapist is sympathetic.

o **Treatment:** Rule out Bipolar Disorder, Manic with paranoid features. Severe lack of insight and resistance to psychological approaches. Biological therapies initially effective despite resistance to medication.

- Frequent diagnoses: schizophrenia (paranoid type), mood disorder.
(Groth-Marnat, 2009)

Treatment Implications

This code type is characteristic of inpatient populations. Psychopharmacological interventions to help control disorganized thinking or regulate mood can often be extremely effective. Because of their disorganized, regressive, and ruminative thought processes, insight-oriented therapy is usually not effective. In addition, their lack of trust and suspiciousness often makes it difficult to form a therapeutic relationship. If a trusting relationship can be developed, concrete, problem-focused approaches are most effective.

Therapy and Therapeutic Pitfalls

Clients with a 6-9 profile are quite guarded, as one would expect from manic and paranoid defenses. Feedback needs to be given carefully as they are sensitive to being seen in any way as mentally ill. They need approval before developing a therapeutic transference. The therapist could point out that their profile suggests they have strong needs to be perfect, above criticism, and moral judgment. Validate that they need to do things the “right way” and that the therapist’s goal is to help them achieve their mission. Help clients identify the source of their current panic about being criticized or judged. Establish trust, and confirm the pain and humiliation of being unfairly disapproved of.

Once the therapeutic alliance is established, the therapist can take the role of “coach,” providing concrete strategies and gentle reality testing. Help clients determine their own goals and ambitions as opposed to the internalized goals of their parents. Explore childhood events of feeling harshly criticized. Help clients engage anger and then learn ways to express it productively. Medication can be useful, but these clients tend to dislike resulting the inhibition of vigilance. In the presence of a history of mania in the families of origin, rule out bipolar disorder. As with any client who is or manic, evaluate for substance abuse. Although these clients may appear loud and intimidating, underneath they are quite fearful and self-doubting.

(Levak, Siegel, Nichols, & Stolberg, 2011)

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you are a very energetic, driven, and ambitious individual. Your mind works quickly and you tend to see the connections between things. You probably have two speeds at which you operate, “full speed ahead” and “off.” You may find yourself experiencing a reduced need for sleep and periods of extremely high energy. You may feel a sense of heightened awareness and perceptiveness, feeling you possess special powers and have been chosen to accomplish great deeds. You may feel that you clearly see who is for you and who is against you. At times, your extreme sensitivity and perceptiveness may actually shade toward paranoia, so that it may be hard for you to know whom to trust, whether you’re being hypersensitive or if, in fact, you are accurately “reading” people. People with your profile often grew up in environments where a parent was loving and demanding, but also critical and judgmental. Perhaps as a highly motivated child you tried extremely hard to be perfect and above criticism. Now you are particularly sensitive to people being critical or judgmental of you, especially since you have such high personal standards. You go through life trying to preempt people being critical or judgmental of you. Currently you may be feeling vulnerable to criticism, rejection, judgment, or attack from others. This may have precipitated an episode of extremely high energy spent protecting yourself against criticism by reaching for extraordinary accomplishments. At times, your sensitivity may be so acute that you actually become confused about whether you are seeing things clearly or whether you are experiencing moments of paranoia. At other times, you may feel so convinced that you have special powers and abilities that you will ignore others’ advice or prohibitions. During this period of high energy, you may become irritable and angry if people block you in achieving your goals. If people are disloyal or you perceive them as in any way harming you, you may feel it necessary to protect yourself in ways that others find frightening. Talk with your therapist about whether you currently feel threatened and what may have precipitated it. In some cases, medication may help you think more clearly and allow you to use your energy productively, rather than be scattered or overcommitted. Identify with your therapist any childhood experiences where you felt unfairly criticized or judged. Explore how that made you feel, without necessarily criticizing your parents, toward whom you may feel quite protective.

Feedback Statements—Elevated Profiles (T-Score > 65)

Strengths

Your profile reveals you have a number of strengths. You are very energetic, ambitious, and driven. You are sensitive and very perceptive. You work hard to protect your loved ones, and security—both emotional and financial—is very important to you. You think quickly, move quickly, and are able to multitask. You are able to see the connections between things, and you can be very productive with big spurts of energy. For you, there’s a right way and a wrong

way of doing things, with little room for shades of gray. You value fairness and loyalty, and you can feel outraged if people do the wrong thing or are disloyal.

High Standards or Fears of Being Criticized

Currently, your greatest strengths can be working against you. You seem to be very wound up, on edge, as if you're afraid of being criticized, judged, or even attacked by others. Being unfairly evaluated is painful to everybody, but to you it's particularly distressing because you work so hard to be perfect. You are a person with very high personal standards. When you make a mistake, you anticipate that others will judge you harshly.

Manic

You may be experiencing very high energy and overcommitment so that it is hard for you to sleep, slow down, and to shut off your mind. Others may perceive you as loud and excitable but also tense, irritable, impatient, abrupt, and angry when confronted or criticized. Much of the time, your mind is racing, and you are preoccupied with how to protect yourself.

Paranoid or Suspicious

Currently, you may be feeling trapped in a situation where you are suspicious that someone has it in for you and wants to hurt you or take something valuable away from you. Although you appear rational, controlled, and determined to take charge, you may feel a sense of panic, and a need to be vigilant to protect yourself against being hurt or taken advantage of. Much of the time, you are trying to understand who is for you and who is against you. At times, your vigilance may shade toward paranoia so that you are unsure of whom to trust. You may find yourself doubting everybody, even people closest to you, wondering if they are planning to harm you.

Anger or Resentment

It's hard for you to express anger or resentment until you feel completely justified in doing so. However, by that time you are very irate because you have bottled it up. At these times your emotions may get the best of you, and you may hurt or frighten someone, or break something. You may spend a lot of time thinking about how to punish people for what they have done. It's important to discuss with your therapist how you can learn to control these feelings.

Hyperrational

Although one of your strengths is your ability to be rational and analytical, currently it might not be working for you. You may be spending a great deal of time trying to analyze, rationalize, and justify what is going on. There are

times when you cannot be sure whether you're seeing things clearly or whether you're being too sensitive, so this confuses and even frightens you.

Jealous or Possessive

You hate to be jealous because you feel it is an irrational emotion. Currently, however, you may be feeling quite possessive and controlling of your loved ones.

Lifestyle and Background Feedback

People with your profile grew up in environments where parents were very critical, judgmental, yet demanding of high performance and achievement. Perhaps you were disfavored relative to your other siblings, so no matter what you did it was never seen as good enough. Possibly your parents' standards were so high that no matter how much you achieved, it was never enough to please them. They may have used physical punishment and shaming as a way of disciplining you. You may have felt that the punishments were excessively harsh and unwarranted. You became preoccupied with looking for signs of unfairness, and you worked hard to be successful, productive, and above disdain. Perhaps as a child, whenever you were very angry you were unable to express yourself because your parents would get only angrier. You have developed a lifestyle of avoiding criticism, seeking approval, and obtaining power and control so that nobody would be able to control or humiliate you.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Treatment and Self-Help Suggestions

1. Explore with your therapist what is frightening you right now or who is threatening to take something away from you so that you can both come up with appropriate ways you can protect yourself.
2. Don't wait until you feel justified in expressing anger or in asking for what you want. By the time you feel you deserve something, you are angry and resentful. Try not to tell people what they have done wrong when you are hurt or angry. Rather, tell them what you need from them. If you tell people what they've done wrong, they feel defensive and want to attack you rather than giving you what you need.
3. Anger when expressed appropriately allows you to preserve your selfworth, convictions, and needs. Assertive anger helps you express your desires in a direct and open way, whereas suppressing healthy anger leads to frustration and resentment. Assertiveness involves monitoring your tone of voice so that it is calm and even and using "I"

statements, such as, “I would like to take a break before we start this project.” Keep a journal and fill in the blank: “What I really need is ” so that you can role play assertive anger with your therapist.

4. See if you can identify any “cognitive distortions” that are triggering negative emotions. Because you work so hard to avoid disapproval, this may trigger your anger with “all-or-nothing” thinking (i.e., I’m either perfect or a failure) or “filtering” (being so vigilant for injustice that you magnify the negative and tend not to see the positive). Work with your therapist to explore where these ideas came from, and then develop some alternate ways of thinking that will help you manage your emotions. You can choose to focus on your own inner balance rather than on other people’s actions.¹

5. Jealousy is a fear of loss. Whenever you get jealous, identify what it is you’re afraid of losing, and try to deal with it. If you are jealous of someone, tell that person your fear of losing him or her or the love he or she gives. Communicating your jealousy with your partner can help you both become more aware of your feelings.

6. Resilience building: Distinguish between your own goals and those of your parents and other authority figures. Work with your therapist to identify your core values, the things you care about deeply and passionately (e.g., honesty, security, beauty, art, nature). How can you incorporate those values into your life, and what support do you need to help you practice these values? The Authentic Happiness Web site contains questionnaires you can take to help you identify your “Signature Strengths” and values:
www.authentichappiness.sas.upenn.edu/questionnaires.aspx.

7. Use thought-stopping techniques whenever you get wound up and preoccupied with who has harmed you. Thought stopping is an effective technique to help prevent these types of unwanted thoughts that can make you feel suspicious or angry. Several forms of thought stopping are effective; one quick technique involves picturing or saying out loud, “Stop,” whenever you experience these types of unwanted thoughts. You then replace the thought with a pleasant image or affirmation that is more positive (e.g., “I have felt this way before, and I know I can handle this”).²

8. Beginning each day with exercise and following a healthy diet can help calm down your high energy level, so you’re better able to handle stress. Practicing healthy habits and taking good care of your body can begin a positive “upward spiral.”³

9. Often, medication can help you regulate sleep and think more clearly and make your moods more manageable. Explore concerns you have about medication with your therapist.⁴

¹ It may help to explain the “ABC” concept of rational emotive therapy (Ellis & Dryden, 1997), where an event (A) leads to a thought (B), which then leads to an emotion (C), so that although clients feel as if the situation is making them distrustful it is actually their interpretation of the event that leads to their negative feeling.

² Many mindfulness-based therapists have criticized the thought-stopping technique as a counterproductive type of thought suppression, but an overview of the literature suggests that, although global thought suppression may be unhealthy, the specific type of thought stopping of unwanted thoughts is highly effective as one of the tools in a cognitive-behavioral model for the treatment of mood disorders (Bakker, 2009).

³ Studies in neurobiology find evidence for the positive and mood-regulating effects of exercise and healthy diet on the brain (Duman, 2005).

⁴ Compliance therapy combines principles of motivational interviewing, inductive questioning, reflective listening, and reinforcing adaptive behaviors and attitudes to explore client ambivalence and target medication adherence (Kemp et al., 1996).
(Levak, Siegel, Nichols, & Stolberg, 2011)

Normal-Range Feedback (T-score 50 to 65)

Your profile is in the normal range. You exhibit a number of strengths, and you are a sensitive, energetic, and ambitious person. You also have high standards, and you work to avoid criticism and judgment from others. Because you value being rational and fair, you have a tendency to analyze your thoughts to ensure that they are reasonable, which means that you may allow anger and resentments to build and then may express them in periodic angry episodes. This tendency to overanalyze may interfere with you being able to spontaneously express your feelings, leading to a buildup of hurt and resentment. Because of your high standards you may be tough on people who may seem to isolate your moral code.

(Levak, Siegel, Nichols, & Stolberg, 2011)

698/968 Codes

In addition to the 69/96 characteristics, the addition of Scale 8 predicts confusion, difficulties in thought and concentration, agitation, and possibly periods of intense, angry reactions and breakdowns in reality testing. Tangential and loose associations are common, as are delusions, paranoid suspiciousness, and in some cases, hallucinations. Hypomanic traits such as high energy, loud speech, and distractibility occur together with mental disorganization, so these individuals can become fixated and preoccupied with odd beliefs, religious messages, paranoid suspicions, and conspiracy theories.

When Scale 8 is within five *T*-score points of Scale 6, see also 68/86 codetypes. See also 69/96 codetypes.

o See 6-9/9-6 and 8-9/9-8. Scales 2 and 0 usually low. Manic hyperarousal with both persecutory and grandiose delusional ideation; and disorganization, agitation, and confusion. May be loud and hostile. Check: *AGGR*, *RC9*.

TREATMENT

See also the treatment sections of the 68/86 and 69/96 codetypes. In some cases, this is a manic disorder that is treated with a mood stabilizer, although in other cases an antipsychotic medication is also required. Paranoid hostility is a primary issue, as is confusion, agitation, and grandiosity, which lead to interpersonal difficulties. The therapist will need to manage the patient's anger and paranoia by being soothing and understanding, non-confrontational but limit setting. Look for early caregivers who were demanding, but hostile, possibly cruel and humiliating toward the patient. These individuals feel damaged, with hypomanic needs to prove themselves. Gentle reality testing and supportive therapy would be more useful than insight therapy.

THERAPEUTIC FEEDBACK LANGUAGE

See 69/96 and 68/86 and 89/98 codes feedback.

60/06 Codes

This is a rare codetype. These individuals experience moderate levels of distress characterized by a generally dysphoric mood, anxiety, low self-esteem, and a quick sensitivity to anything that can be construed as criticism or judgment. These individuals experience themselves as more sensitive than others, and report feeling things more intensely than others. Consequently, their feelings are easily hurt and they are inclined to take things personally. Others may see them as "touchy" and socially awkward.

They readily experience feeling criticized, and see themselves as easily pushed around by others. When stressed, they may exhibit episodes of intense anger that comes as a breakdown of brittle control. These individuals tend to lack confidence. Even though they see themselves as rational, clear thinkers, with good judgment and memory, they also feel very self-conscious and socially alienated, perhaps reflecting the combination of shyness and sensitivity to being criticized. Their sensitivity can shade toward paranoia, with a misunderstanding of others' motives, unreasonable jealousies, and concerns that others are talking about them (ideas of reference). They are shy, uncomfortable in social situations, and easily embarrassed. In social events, they tend to stick to people they know and avoid spontaneously "joining in." They tend to hang back and not speak unless spoken to, and some report feeling lonely. Others may see them as honest, unassuming, reliable, and loyal once a relationship is formed. At the same time, they would be seen as somewhat prickly and unapproachable. Often they store resentments and allow them to accumulate until some particular event leads them to lash out in a highly rationalized outburst.

Concerns about being sufficiently physically attractive are also common. In some cases, a clear paranoid disorder is present, although it is not of a fragmented kind, as with schizophrenia, but a fixed, rational paranoia that is focused on a particular person or institution.

o Anxious and dysphoric. Socially avoidant and timid. Look for isolation, alienation, suspiciousness, guardedness, hypersensitivity, obsessiveness, and transfer of blame. Check third highest scale.

1. Women counselees with this pattern have feelings of inferiority in regard to some physical feature and shyness (Drake & Oetting, 1959).
2. Individuals with these elevations tend to be quite paranoid and may be psychotic, although they do not show the fragmentation of thought processes typically seen with schizophrenia (Triniboli & Kilgore, 1983).

Description:

Shy, easily embarrassed, have distant relationships, but usually well adjusted

TREATMENT

Look for childhood conditioning experiences of a critical or punitive caretaker. Harsh scolding and shaming as a way of controlling the child would be typical. Help them learn to articulate needs, hurts, and resentments directly, rather than waiting until they feel justified and then expressing them as a rationalized, angry, blaming outburst. Help them understand that others' insensitivities toward them are not necessarily conscious attempts to hurt or humiliate them, and that their tendency to withdraw into hurt silence is also an expression of anger that engages others' anger toward them. Normalize introversion as a genetic trait rather than a "defect," and use assertiveness training and social skill building to decrease loneliness and social awkwardness. Prognosis should be good because they tend to follow prescriptions, but they tend to distrust and doubt the effectiveness of talk therapy, so the initial therapeutic alliance is difficult to establish. Although they would initially be uncomfortable with group therapy, a social skill-building group can be helpful. Discuss how they feel misunderstood by others and how painful it is to not be able to trust others with their intimate feelings. Encourage them to role-play "bragging" about some of their accomplishments to help them develop a better ability to accept compliments from others. Sex therapy can also be useful, as many of these individuals are afraid of letting down their guard and being vulnerable, resulting in marital discord.

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you are quite shy, which means you're uncomfortable in large groups of people you do not know. People with your profile often prefer small groups of established friends or one-on-one conversations with somebody they know. You are quite sensitive, so pushy, demanding, or insensitive people can cause you a great deal of discomfort. You tend to have very high standards and are your own worst critic so others' criticisms or judgments are particularly painful, and you may find yourself ruminating about them. One of your parents may have been somewhat harsh and critical, or perhaps used shaming or severe punishments as ways to discipline you. They may also have not understood your sensitivity and how hurt you were whenever you were treated unfairly or harshly. You appear to be going through life cautious about letting down your guard, as if anticipating being criticized, judged, or unfairly treated. Sometimes it may be hard for you to distinguish between when you are being too sensitive and when, in fact, you have accurately perceived that hostility is being directed against you. Sometimes your sensitivity may lead to episodes of paranoia, where it is hard to know whom you can trust. Work with your therapist at understanding that your shyness and sensitivity are probably genetic and do not reflect that there is something wrong with you. Remember that many people are insensitive and when they hurt you, often it is out of clumsiness or lack of awareness rather than an attempt to consciously harm you. Work on expressing hurt and anger when you feel it, rather than waiting till you feel "justified" in expressing it. If you wait until you feel justified, by then you are often so angry that it is hard to forgive the other person. Perhaps join a group with other people who are also shy, so that you can realize that you are not alone, and learn some techniques for how to manage insensitive people. Learn to switch off your self-critical thoughts and use CBT techniques to manage your anxiety. You probably will feel uncomfortable engaging in psychotherapy because you are a private person who finds it difficult to discuss your feelings with a stranger. Discuss with your therapist how you can structure the therapy sessions to help you to feel most comfortable.

Scale 7 (Pt)

Spike 7

Scale 7: Psychasthenia (pt)

Descriptors

Complaints

Anxiety, insomnia, fears of failure, insecurity, possible phobias, obsessions, compulsions, procrastination, self-consciousness, impaired concentration and memory, dysphoria, lack of confidence, guilt, self-criticism, somatic symptoms, suicidal ideation

Thoughts

Obsessive, self-critical, analytical, preoccupied with fears of failure and criticism, indecisive, ruminative, guilty, perfectionist, overrideational, moralistic

Emotions

Feeling panicked, anxious, apprehensive, insecure, guilty, softhearted, moody, tense

Traits and Behaviors

Anxious, ruminative, high-strung, obsessive, perfectionist, compulsive, dependent, trustworthy (especially if Scale 4 and Scale 9 are low), conscientious, dutiful, self-effacing, interpersonally sensitive, dysthymic, possibly suicidal, poor coping

(Levak, Siegel, Nichols, & Stolberg, 2011)

Therapist's Notes

Scale 7 scores below 50 have been associated with positive adjectives such as cheerful, relaxed, self-confident, and placid. These clients are also efficient, capable, and able to mobilize their resources easily and effectively. Their low level of anxiety and worry can, however, lead to ignoring important details, taking imprudent risks, and being too relaxed about deadlines. In the normal range, Scale 7 suggests clients who are conscientious, responsible, and dependable. They have a tendency to become anxious, worried, and insecure, and are concerned about

disappointing people. They have difficulty making decisions because they examine all possible ways things can go wrong. Even in the normal range, if elevations are not due to Correction (K), they are afraid of disappointing others and are quick to feel guilty and inadequate. These individuals are reliable, conscientious, dependable, guilty, detail oriented, and trustworthy. The primary complaints associated with elevations on Scale 7 are worry, anxiety, and dread. These clients feel on edge, as if some unpredictable event will lead to catastrophe. They are vigilant scanning their internal and external environment in an attempt to anticipate and prevent something from going wrong. The capacity to predict and manage threats may be survival related. It would make intuitive sense that the aptitude to anticipate danger would be normally distributed in the general population, with some people highly sensitive and others having a higher tolerance for uncertainty. Clients with an elevation on Scale 7 overanalyze their own behavior, the observing ego maintaining control, perhaps in an attempt to preempt guilt over failure. Living with a heightened sense of anxiety, they tend to develop superstitions, obsessions, and compulsions. These individuals seek reassurance from others but are unable to trust it when it is received. Pervasive apprehension serves as a preemptive defense against the possibility of unpredictable failure. Guilt serves as a reminder to stay vigilant. They don't trust others' watchfulness for things going wrong because they lack confidence that others will be as thorough and as responsible as they are. When they seek advice, they doubt that the advisor has thoroughly understood the problem. Any major decision becomes anxiety provoking, and they tend to see every side of every issue. The more counsel they get, the more anxious and self-doubting they become. Their high level of tension and anxiety is often manifested as somatic symptoms, which causes more distress. Understandably, dysphoria is a common complaint as stress and tension crowd out the ability to enjoy life. These individuals are conscientious and overly responsible. They tend to gravitate toward responsibility out of a compulsive sense of duty and then become overloaded and overwhelmed by it. Nevertheless, they often procrastinate due to their need for perfection and their reluctance to be criticized for performing inadequately. They are their own worst critics and find praise difficult to accept. They are unable to show even a modicum of appropriate anger and self-assertion. Phobias, obsessions, and specific ruminations serve as a way of binding and reducing anxiety. Unsurprisingly, with this amount of internal "noise" and the constant chatter of self-monitoring and analysis of every situation, they have difficulty with concentration and memory. Sometimes they're diagnosed with attention deficit disorder (ADD; Downey Stelson, Pomerleau, & Giordani, 1997), although the attention problem is one of interruption due to anxiety rather than true ADD. Perceived failure, especially if shame is involved, is experienced by them as catastrophic and can lead to suicidal ideation. Scale 7 is rarely elevated on its own. When it is, and if it is not a result of high Correction (K) (the full K raw score is added to Scale 7), then it reflects a generalized, anxious state without any specific focus. However, elevations on the other clinical and content scales reflect the focus of the anxiety. The 1-7 code types, for example, fear bodily damage, whereas the 2-7 code

types fear loss.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Lifestyle and Family Background

In combination with a genetic predisposition, early childhood experiences of clients with high Scale 7 often involved an adaptive response to being flooded with anxiety subsequent to an unpredictably frightening childhood event or a series of events. High 7 individuals have modified their behavior through hypervigilance in an attempt to predict any onset of a painful and potentially panicking event. Given this fear, it makes sense that they scan the environment to anticipate how others could be disappointed, and to perform rituals and compulsions to reduce anxiety. The high 7 response of protecting against the onset of unpredictability is to anticipate all eventualities. Unlike Scale 4 or Scale 8, which entail distancing, fear of involvement, and an insecure or absent attachment, Scale 7 reflects a strong desire for connection, validation, love, and approval. Fearful of the bond being disrupted and willing to sacrifice to maintain it, the high 7 is on alert not to disappoint or lose others' love and approval. Unpredictable losses, humiliations, setbacks, or poverty could also increase vigilance to protect against the onset of panic surrounding a recurrence of these events. Guilt about relaxing would maintain a high drive state.

(Levak, Siegel, Nichols, & Stolberg, 2011)

This is a relatively uncommon profile because Scale 7 has a number of items that overlap the other clinical scales, especially Scale 2 and Scale 8. High scores ($T \geq 65$) on this scale suggest an individual who is tense, anxious, guilty, and self-critically introspective. These individuals are self-conscious and feel insecure, inadequate, and inferior. A lack of self-confidence creates a tendency to procrastinate and feel overwhelmed by the responsibilities they feel obligated to undertake. They underestimate their own abilities in spite of evidence of successes. They are indecisive and suffer from "analysis paralysis" and general apprehension. In some cases, high elevations can also lead to physical symptoms associated with anxiety.

Scores in the normal range (T -55–65), the absence of a significant K elevation, would suggest an individual who takes life seriously and is prone to worry, with occasional anxious episodes as stress accumulates. Some individuals with Scale 7 in this high normal range can also exhibit obsessive–compulsive traits that others see as productive rather than disorganizing or debilitating. Others in this range may exhibit a specific fear or phobia.

Moderately low scores (T -35–45) in the absence of any other elevation above a T -score of 55 reflect an individual who is relaxed, comfortable, and without emotional distress. Generally self-confident and adaptable, others will see them as efficient and capable. However, their lack of anxiety in some cases may lead to inefficiency and missing deadlines.

Even in psychiatric populations, peaks on scale 7 are not particularly frequent. Black did not find any striking shifts over the adolescent and early years of maturity for the occurrence of peaks on this scale. Sundberg (1952) found relatively more of these peaks in acute outpatient groups of psychiatric patients than in hospitalized groups (see Appendix M). There is a striking absence of these patterns in the prison populations studied by Panton (1959; see Appendix M). There are only a few adjectives in Black's findings on college women who had peak scores on scale 7. The peers of these girls typified them as kind, dependent, quiet, and trustful. Drake reported that counselors found a group of college counselees with peak scores on scale 7 to be unresponsive in the interview. The net effect of the operation of these personality traits seems to be that other people do not get to know these subjects very well. The list of terms that the peer judges in Black's study failed to endorse seems to reveal this same trend. The scale 7 peak women were not described as alert, individualistic, or aggressive. The terms friendly, enterprising, energetic, and independent were also omitted. Other items significantly considered to be uncharacteristic included clever, idealistic, self-centered, and impatient. In their self-descriptions, however, these girls presented a more complete picture. They conceived of themselves as being gloomy, depressed, and emotional, with many physical complaints. They said they were dreamy, sentimental, softhearted, and indecisive. In addition, they viewed themselves as unpopular and dependent, irritable and suspicious, and absent-minded. They failed to endorse many terms in their self-descriptions as well. They did not see themselves as easygoing, independent, aggressive, or self-confident. Nor did they say they were alert or lively, worldly or adaptable, clear thinking, loyal, or show-offs. According to Mello and Guthrie, the college counselees who had peak scores on scale 7 in their study were characterized by obsessive-compulsive ruminations and morbid introspective trends. The problems of these students were centered about poor study habits, poor personal relations, and difficulty with authority figures. They were very concerned about religious values and morality, and many had problems with homosexual impulses. As a group, these clients were the most seriously disturbed of the college counselees in the study. They showed strong resistances in therapy, developing considerable hostility toward the therapist and toward treatment itself. However, these counselees persisted in therapy longer than any other code group, their dependency increasing markedly with the number of interviews. Improvement came only slowly, with no dramatic remission of symptoms. Medical patients with scale 7 as a peak score were characterized by Guthrie as prone to worry, anxious, fearful, and rigid. They presented medical problems that frequently centered about their hearts, with gastrointestinal and genitourinary difficulties also represented. However, the dramatic feature of these cases was their extreme concern about their medical difficulty; they required many return visits and repeated reassurances. Depression was present, but even in the 72 codes, it was less clearly manifested than was agitation and anxiety. Whatever their problem, they seemed as a group unable to modulate their reactions to the actual events, but rather characteristically overreacted. It has also been reported that college

students with 7 peaks were particularly conscientious in reporting for psychological experiments and gave an unusually high number of uncertain judgments in the course of such experiments on a discrimination task (Griffith, Upshaw, and Fowler, 1958; Griffith and Fowler, 1960).
(Dahlstrom, Welsh, & Dahlstrom, 1979)

o Look for anxiety, obsessiveness, dependency/passivity, guilt, indecision, and inadequacy/inferiority. Check second highest scale.

Description:

Shy, fearful, phobic, obsessive-compulsive, tense

Modifying Scales

■ When K is elevated above a T-score of 60, the anxiety, worries, and obsessions are more focused and less diffuse and pervasive. The high K high 7 code types are organized, efficient individuals whose anxiety may be egosyntonic.

■ When Scale 7 is elevated and K is low, the individuals will often experience frequent and debilitating anxiety. They may use chemical agents as a way of self-medicating.

■ Elevation on Scale 1 would predict panic and anxiety around the possibility of body damage. If Health Concerns (HEA) or Somatic Complaints (RC1) are elevated, the anxiety would center on specific bodily functions, fears of decline, and impending death.

■ Elevation on Scale 2 would predict fear and apprehension about any type of loss. The 7-2 is obsessively unhappy and worn out by worry. Elevations on Depression (DEP) or Low Positive Emotion (RC2) may reflect the exhaustion due to constant worry rather than an endogenous depression.

■ Elevation on Scale 8 suggests a preoccupation with avoiding being humiliated and being exposed as an undesirable, unlovable, and broken human being. If Bizarre Mentation (BIZ), Psychoticism (PSYC), or Aberrant (RC8) Experiences are elevated, there is a possibility of a psychotic process against which the person is actively defending.

- Elevation on Scale 9 would suggest anxiety and worry about failure and a fear of missing out on opportunities. The energy and drive of high 9 would increase the anxiety of Scale 7 but with a focus on achievement, success, and a protection against unpredictable loss.

- Typically, Anxiety (ANX) or Dysfunctional Negative Emotions (RC7) will also be elevated unless Scale 7 is elevated by Correction (K). If ANX is not elevated in the presence of high K and Scale 7, the tension would be more focused and egosyntonic.

- When Fears (FRS) is elevated, especially Multiple Fears (FRS2), inquire about specific fears and phobias such as the fear of heights or snakes. If Social Discomfort (SOD) and Scale 0 are elevated, consider social phobia.

- The Obsessions (OBS) subscale is not always elevated, but when it is it would predict indecisiveness and perhaps specific obsessive behaviors and thoughts.

- Typically, Work Interference (WRK) is elevated, as one would expect with someone who is perfectionistic, compulsive, and self-doubting.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Male

Low 0 One interview only, lacks knowledge or information.

Low 1 Nonresponsive or nonverbal.

Nothing Low Lacks skills with the opposite sex, mother conflict, sibling conflict, nonresponsive or nonverbal, tense, indecisive, unhappy, worries a great deal, insomnia, confused.

Female

Low 3 Cried in the interview.

Low 5 Anxieties, nervous, exhaustion, insomnia, headaches, lacks self-confidence, indecisive, socially insecure.

Nothing Low Headaches, sibling conflict.

(Drake & Oetting, 1959)

TREATMENT

Scale 7 is often the most frequent high point on profiles of individuals in college counseling centers. Because of the item overlap, Scales 2 and 8 may also be elevated (see 278/728 codes). Look for childhood experiences of either a number of unpredictable traumatic or negative events, or a single traumatic unpredictable event that left them emotionally overwhelmed and panicked. In some cases, these unpredictable negative events were teasing or unpredictable explosive episodes directed at them by a caretaker. In other cases, the unpredictable event may have been the sudden loss of a parent, with the resulting loss of age-appropriate carefreeness. Spike 7 codetypes are among the easiest to deal with therapeutically because these individuals follow advice, are disciplined, honest, and quick to feel guilty if they do not follow through on therapeutic commitments. Work on transference issues, as they expect the therapist to become impatient with them and are preoccupied with avoiding disappointing the therapist. Relaxation training, hypnosis, self-esteem building, thought stopping, and catharsis around past unpredictable traumas can be useful. Help them learn to express anger directly, without guilt or fear that anger expression could lose the support of loved ones. Also help them to develop better self-esteem. They gravitate toward taking on responsibilities out of guilt and then feel overwhelmed and panicked by the ensuing burden. They fear failure because of the shame and guilt that accompanies it. With teenagers whose Scale 7 is significantly below *T*-50, therapy should focus on raising their level of motivation by judicious parental consequences in order for them to develop appropriate levels of anxiety.

Therapy and Therapeutic Pitfalls

Individuals with elevations on Scale 7 are amenable to therapy and, in many ways, are model clients. They are diligent, responsible, and want to please and follow instructions. However, their tendency is to distrust that people fully understand the complexity of their world or have the discipline and attention to detail necessary to comprehend the problems they experience. Validating the details of their concerns tends to inspire trust. Because these clients value thoroughness, therapeutic transference is most likely to occur when the therapist takes careful notes, asks many questions to understand the exact nature of their problems, and does not offer advice or diagnoses prematurely. These clients are highly sensitive to anything that can be construed as criticism. When clients start to anticipate therapist disapproval with statements such as, "I know you're angry about this," it signals transference. High 7 individuals dread making changes and need reassurance to do so. Validating the disabling effects of anxiety tends to be helpful in establishing trust. Often, didactic information, such as explaining the physiological response to anxiety and how it develops and is maintained, can be helpful. Cognitive-behavioral therapy (Stewart & Chambless, 2009) and systematic desensitization (McGlynn, Smitherman, & Gothard, 2004) have proven successful. Insight-oriented therapies are useful in helping them to understand the origins of their anxiety, although psychoanalytic

therapies may aggravate already overly introspective tendencies.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Treatment and Self-Help Suggestions

- You have likely sought help because your anxiety feels overwhelming and because you're experiencing symptoms of stress. Anxiety disorders are the most common mental health problems in the United States,¹ and many effective and well-researched treatments are available. The suggestions that follow will outline effective treatments, but for general information about anxiety disorders you can contact the National Institute of Mental Health (NIMH) at (888) ANXIETY or (888) 269-4389. The NIMH Web site is <http://www.nimh.nih.gov>.
- 1. Learn to stop your thoughts when they begin to get out of control. Work with your therapist to identify some of the more "intrusive" or anxiety providing thoughts that you have. "Thought stopping" is an effective technique you can practice to help you prevent the types of unwanted thoughts that can make you feel anxious. Several forms of thought stopping are effective. One quick technique involves picturing or saying out loud, "Stop," whenever you experience these types of unwanted thoughts. You then replace the thought with a pleasant image or affirmation that is more positive (e.g., "I have felt this way before, and I know I can handle this").
- 3. Learn to meditate for a short time period every day to slow down or even stop your constant stream of thoughts. Many types of meditation practices have been demonstrated to help control distracting thoughts and to improve concentration and focus. One simple meditation technique involves sitting comfortably for 10 to 15 minutes each day with your eyes closed, silently repeating a sound, word, or phrase (called a mantra) to calm the mind and body. Overall, the regular practice of meditation is linked with many long-term positive effects such as increased positive emotions, attentional abilities, and emotional stability.²
- 4. Learning various types of intentional relaxation can help calm your automatic reactions to stressful situations. One type of relaxation, diaphragmatic breathing, exerts a powerful effect on your physical response to stress. When you feel threatened your breathing is rapid and shallow, but this exercise can calm the automatic response of your nervous system and reduce reactive thinking and destructive emotions.

Work with your therapist to learn diaphragmatic breathing, practice twice daily for 2 weeks, and then continue to practice on a regular basis.³

5. Work with your therapist to remember an event or series of events in which you felt completely taken off guard. Recall what it felt like. As you think about the frightening, unexpected event, close your eyes, take a deep breath, and use diaphragmatic breathing to relax. After repeating this process several times, you may find that the painful event is less upsetting.
6. Mindfulness is a way to begin to manage your emotional responses; it involves paying attention to the present moment in a nonjudgmental way and fostering a quality of curiosity and openness.⁴ For more information on mindfulness exercises see www.mindfulnessstapes.com. You can begin by setting aside time to watch the moment without analyzing or judging it. Pay attention to the sight, sound, taste, smell, and feel of the experience. Engaging in a daily practice of mindfulness can help you manage powerful emotions.⁵
7. Work with your therapist to identify how automatic negative thoughts (ANTs) influence your feelings and your behavior. With practice, you can change the negative thought patterns that lead to anxiety. Examples of ANTs include, “I will never get this right,” “I should have known better,” or “I am sure that she doesn’t like me.”⁶
8. Daily exercise, especially aerobic exercise, can help reduce anxiety and also can help improve your general mood. Avoid caffeine. Try to incorporate a regular program of exercise into your daily routine.⁷
9. Resilience building: If something goes wrong, try not to beat yourself up. Self-forgiveness begins with accepting the fact that you are human and can make mistakes. Instead of feeling remorse, think about what it is you regret, what you wish you had done differently, and what you can change. Make a list of your “Signature Strengths” that will help you the next time you are in a similar situation. For help identifying your signature strengths go to www.authentichappiness.sas.upenn.edu/questionnaires
10. Learn to recognize when you are angry with someone and attempt to deal with it directly. Don’t assume that you’re always at fault in any interpersonal misunderstanding. Learn to ask for what you want early in the process so you don’t develop resentment.

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- ¹ Generalized anxiety disorder (GAD) and other anxiety disorders such as panic attacks, phobias, obsessive-compulsive disorder, and posttraumatic stress disorder, are among the most common mental health problems (Kessler, Chiu, Demler, & Walters, 2005).
- ² Neuropsychological studies examining the effects of both short- and long-term meditation using magnetic resonance imaging (MRI) have found great promise in the positive effects of meditation on cognitive structures and processes. Although empirical studies of meditation are still in a stage of infancy, research is linking improvements in both psychological and physiological well-being to meditation (Luders, Toga, Lepore, & Gaser, 2009).
- ³ When engaging in relaxation exercises, the parasympathetic nervous system (PNS) is activated, slowing heart rate, breathing, and blood pressure. When the PNS is activated, the body enters a restorative mode that counteracts the effects of stress (Roberts, 2009).
- ⁴ Bishop et al. (2004) explain mindfulness as an acceptance of the present moment and a playful and curious awareness.
- ⁵ Mindfulness and compassion can play a powerful role in helping people who have internal feelings of being overwhelmed by self-contempt or troubling thoughts (Gilbert & Tirsch, 2009). Orzech, Shapiro, Brown, and McKay (2009) studied the role of intensive mindfulness training on changes in psychological symptoms and found significant increases in well-being, self-compassion, and resilience and decreases in anxiety after 1 month of mindfulness training.
- ⁶ Cognitive-behavioral therapy (CBT) has been well established as an effective treatment for anxiety in both laboratory and real-world therapy settings (Stewart & Chambless, 2009). Meta-analysis was as effective as pharmacological treatment and was associated with long-term treatment gains, revealed that CBT (Gould, Otto, Pollack, & Yap, 1997).
- ⁷ Results of cross-sectional and longitudinal studies consistently find that aerobic exercise has antidepressant and anxiolytic effects. It also can protect against the harmful effects of stress (Salmon, 2001). (Levak, Siegel, Nichols, & Stolberg, 2011)
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THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests you are a dutiful, responsible, honest, and reliable person who experiences a constant level of worry and apprehension. It is as if you are always preparing for some unforeseen negative event, analyzing the future for what possibly could go wrong, and ruminating about your past behavior, usually finding something to feel guilty about. You often take on responsibilities and readily feel guilty if you make mistakes. It is hard for you to see your positive accomplishments. You often experience a sense of dread, even when you have no tangible reason to do so. It is hard for you to assert yourself and you feel guilty if you express anger toward others, even if others tell you that

your anger was justified. You may have developed some rituals or behaviors that you compulsively practice, perhaps obtaining some temporary relief from anxiety in doing so.

You may have experienced some unpredictable painful events in the past, such as childhood teasing, losses of loved ones, or overloads of responsibilities to which you adapted by becoming constantly “on edge,” attempting to predict and preempt guilt-inducing setbacks. Learn to recognize when you are experiencing anxiety and switch off the negative thoughts. Write down a list of your worries and preoccupations about possible future disasters and then make a list of all the things that could go well, so that you can maintain a balanced perspective. Take a meditation class and use biofeedback as a way to self-soothe. Explore with your therapist any past unpredictable events that conditioned you to preemptively worry. Develop a sense of empathy for yourself so you can begin to learn to relax and celebrate your accomplishments without guilt.

Feedback Statements—Elevated Profiles (T-Score > 65)

Strengths

Your profile reveals a number of strengths. You are a thoughtful, analytical, responsible individual who takes life seriously. You tend to be detail oriented, reliable, and thorough. You generally follow the rules and are trustworthy. Dutiful and conscientious, you’re the kind of person people can count on.

Anxious or Worried

Currently, however, some of your strengths may be working against you. You may spend a lot of time standing back and observing the world, worried that some mistake you make will lead to catastrophe. You often feel a sense of anxiety, as if something bad is about to happen. Even when things are going well, it’s hard for you to switch off your mind to get rid of that feeling of nervousness.

Analytical, Obsessive, Guilt Prone

It’s hard for you to be spontaneous because you see every side of every issue. When you have to make a decision, you are likely to overanalyze, worrying that you might have missed some important detail. Part of the reason you fret so much about making a mistake is that when something goes wrong you feel so deeply guilty. Not only do you focus on possible future mistakes, but you also spend a lot of time thinking about the past, about oversights you’ve made, and obsessing about how much guilt you should feel.

Self-Critical

You tend to be your own worst critic. Even when things go well, you can't relax and enjoy them. When people compliment you, it's hard for you to get pleasure from it because you feel undeserving. Perhaps you're afraid that if you enjoy any successes and if you pat yourself on your back you'll make a mistake and regret having celebrated any victories. Staying on edge, and not letting yourself enjoy life are ways for you to protect yourself against being disappointed should you fail at something.

Difficulty With Concentration or Memory

Being on edge and obsessing about all the possible things that could go wrong likely makes it difficult to concentrate. Your own inner thoughts often interrupt you, making it difficult to remember things. It's hard to "log in" new information if your mind is preoccupied with everything that might go wrong.

Difficulties With Sleep or Substance Abuse

This worry and tension likely tires you out and leaves you exhausted. It's hard to relax when your mind is preoccupied, so falling asleep is probably difficult. No wonder you wake up exhausted in the morning. Sometimes people with your profile use chemical agents as a way of calming down. Be careful as they may actually aggravate your anxiety.

Compulsions or Phobias

People who worry a great deal often develop superstitions, obsessions, compulsions, and phobias. If something frightened you in the past, it's easy for you to feel like you have to stay away from it. You might have some compulsions or eccentric ways of doing things, perhaps as a way to lower your anxiety. For example, you may make mental lists of everything you need to worry about.

Lifestyle and Background Feedback

People with your profile were often tense and high-strung children. Perhaps you were a "late bloomer" or had some personal eccentricities that made you vulnerable to being teased or put down. You may have been sensitive about failing in any way, and quick to feel guilty if you were scolded. A parent or authority figure may have been controlling and hovering and inadvertently made you feel like you weren't quite good enough. In other cases, a major upheaval or series of unpredictable events may have put you on alert, always waiting for "the other shoe to drop." You adapted to this stress, scanning your environment to see what could go wrong next. Now you're going through life unable to relax and attempting to protect yourself against some unexpected catastrophe. You have learned to dislike surprises, even those with pleasant and happy connotations.

Normal-Range Feedback (T-Score 50 to 65)

Your profile is in the normal range and shows that you have a number of strengths. You are a thoughtful, analytical individual who takes responsibilities seriously. You have a mild tendency to worry and be anxious about things going unpredictably wrong. This may mean that at times you make mental lists so you can stay “on top” of your responsibilities. Making decisions can, at times, be difficult for you because of you are apt to see everything that can go wrong with any choice you make. Whenever things do go wrong, you are likely to blame yourself and feel guilty. Because you can see all the possible ways things can go badly, you are likely to avoid taking risks. Generally, confrontations are difficult for you, so you worry if you have to confront someone.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Relations with Other Scales

71/17 Codes

See 17/71 Codes.

72/27 Codes

See 27/72 Codes.

See also the 27' s described above. Drake found that college counselees with this code pattern very frequently fell into problem groups characterized as tense and indecisive.

(Dahlstrom, Welsh, & Dahlstrom, 1979)

7-2 See also the 2-7 combination, p. 106.

- With the 7-2 profile less depression but more anxiety and agitation is present than with the 2-7 profile (Guthrie, 1949).

73/37 Codes

See 37/73 Codes.

74/47 Codes

See 47/74 Codes.

75/57 Codes

See 57/75 Codes.

76/67 Codes

See 67/76 Codes.

78/87 Codes

Code-Type 7-8/8-7

Descriptors

Complaints

Acute turmoil, anxiety, obsessive-compulsive symptoms, nervousness, somatic complaints, suicidal ideation, sometimes hallucinations, anhedonia, depersonalization, derealization, negative self-image, memory or concentration problems, guilty, social withdrawal, possible social phobia, self-conscious

Thoughts

Self-doubting, painfully introspective, obsessive, ruminative, indecisive, fantasizes, sometimes sexual or violent content (does not predict actual violence), disrupted thinking, delusional, brooding, identity concerns, somatic preoccupations, suicidal ideation

Emotions

Feels inferior, damaged, or unlovable; anxious; fearful; nervous; guilty; resentful; moody; anhedonic; ambivalent

Traits and Behaviors

Insecure, anxious, ruminative, self-doubting, passive, possible thought disorder, alienated, socially fearful, feels damaged/broken/unlovable

(Levak, Siegel, Nichols, & Stolberg, 2011)

People with the 78/87 codetype have numerous symptoms and personality traits in common, but the scale order determines differences between them. When Scale 7 is higher than Scale 8, the individual is likely experiencing severe anxiety around what they perceive as a disintegration in their ability to control their thinking and feelings. A high level of anxiety in the presence of a potential thought disorder suggests an adaptive attempt at “thinking their way through” a sense of impending disorganization. When Scale 8 is elevated significantly above Scale 7, the individual has adapted to feelings of alienation and cognitive disorganization, and is no longer attempting to defensively cope. The 87 individual is, therefore, likely to be more seriously disturbed than the 78. Individuals with the 87/78 codetype experience the following in common: They manifest worry, anxiety, dysphoria, fears and phobias, tension, obsessive thinking, and rumination. They are excessively introspective, view themselves negatively, and experience confusion and occasional breakdowns in reality testing. They experience the world as unsafe and feel a constant sense of apprehension and dread. These individuals obtain little pleasure from life. They take things personally and ruminate about how others are critical of them and do not like them. They are quick to feel irritated by minor setbacks, and see others’ suggestions or advice as criticisms and judgments. These individuals tend to be passive, inviting rescue, and allowing others to control them, but then resenting it and feeling bullied. When feeling cornered, they can be explosive and, thereafter, feel humiliated. They have difficulty thinking clearly, concentrating, and effectively problem solving. They experience sleep hygiene problems and may exhibit specific fears, phobias, and compulsions. Suicidal thoughts are common. When Scale 8 is higher than Scale 7, suicide attempts can be bizarre and involve self-mutilation. Some 87 individuals can also experience hallucinations or delusions. Odd or even bizarre preoccupations are common, such as worrying about their pituitary gland or other symbolic expressions of feeling damaged. Not all 87/78 individuals show psychotic disintegration, however, although many experience at least occasional breakdowns in reality testing. 87/78 individuals lack confidence and feel inadequate. Poor sexual performance is likely since they are painfully self-aware and self-doubting. Achievement tends to be poor because of chronic low self-esteem and lack of self-confidence. Some use chemical agents as a way to medicate their anxiety. Depersonalization and de-realization as well as isolation of affect are typical. These individuals see themselves as “damaged goods” and anticipate that they are going to be exposed as such and humiliated. They have difficulty making decisions and often feel they “lose out” because they are unable to make up their mind quickly enough. They often experience invasive thoughts interfering with concentration and memory. The 87/78 individual experiences a constant sense that he has done something wrong or that he is inherently evil. Often these individuals are quite introverted, easily embarrassed, and have poor social skills and judgment. Sexual fantasizing is common, though actual sexual contact is infrequent because of their interpersonal difficulties.

Therapist's Notes

In the normal range the 7-8 code type indicates individuals who are analytical, creative, and thoughtful. They are often detail oriented and cautious about making mistakes. These clients have a mild tendency toward self-blame and may also experience anxiety, especially when making important decisions. They readily feel guilty and insecure and are quick to feel inadequate. Rejection from a loved one is particularly threatening.

Higher elevations on 7-8 reflect the interplay of neurotic, anxious, reassurance-seeking traits with schizotypal, withdrawing, confused, and identity-damaged traits.

If Scale 8 is significantly higher than Scale 7 (8 or more points), there is a higher probability of schizotypal thought processes and possible psychosis. When Scale 7 is significantly higher than Scale 8, the code type reveals a more neurotic adjustment, although the extent of identity damage can still be substantial.

The 7-8 code types (as opposed to 8-7 code types) are anxious, obsessive compulsive, self-doubting, and on edge, anticipating rejection and humiliation. Although they have an unrealistic negative self-image and a diffuse paranoia about being rebuffed, they rarely exhibit psychotic symptoms. Their anxiety can involve preoccupation with somatic symptoms, which become a source of further anxiety and can confirm that they are somehow damaged. It is not surprising that Scale 2 is often elevated third: sleep problems, suicidal ideation, and ruminations about how others see them negatively characterize the 7-8 code type. Depersonalization and derealization are common complaints with both the 7-8 and 8-7 code type.

The 8-7 code types are more likely to experience schizotypal symptoms with diffuse paranoia around being slighted or shamed. The 8-7 code types have distorted reality testing. They tend to ruminate and create elaborate fantasies about others' negative view of them or cruel intentions directed toward them. In an attempt to manage these distortions, they may develop superstitions and compulsive behaviors that appear odd or inappropriate.

Both 7-8/8-7 code types can be described as highly dependent, insecure, and lacking in feelings of self-efficacy. While needing a great deal of reassurance, they are terrified of the vulnerability associated with asking for emotional support. These clients are chronic worriers who feel on edge and fearful that, at any moment, they will somehow slip up and reveal their defectiveness. As one would expect with high Scale 7 elevations, they feel compulsive guilt.

Remorse serves as a steady reminder to stay vigilant against the possibility of disappointing loved ones. Relationships are frightening because these individuals assume inevitable abandonment, fearing that anyone who would love them will eventually see their obvious defects. These individuals experience difficulties with concentration, memory, and decision making and, at times, relatively severe thought disruption. This code type is associated with a rich though fractured inner fantasy world. They tend to be preoccupied with religious and philosophical issues, perhaps as a way of seeking meaning in a world they find frightening and alienating. They often develop esoteric personal

philosophies that justify their sense of isolation. Individuals with this profile have a sexual life that tends to be more ideational than actual.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Lifestyle and Family Background

The 7-8 code type reflects individuals who experienced unpredictable putdowns and humiliations in childhood. As children, they were sensitive, slow to mature, or may have exhibited personal eccentricities and peculiarities that left them vulnerable to being teased, put down, or humiliated. In some cases, they may have been overprotected and in the process they felt inferior to peers or siblings. They go through life replicating this early attachment style, feeling inadequate and incapable. Maintaining vigilance and internally rehearsing the consequences of being disgraced make adaptive sense as a way to reduce the impact of possible unpredictable rejection. Isolation of affect, depersonalization, and observing rather than participating would serve to defend against the pain of harsh, sudden disapproval. Escape into fantasy would be an adaptive response to early conditioning experiences of shame and rejection.

(Levak, Siegel, Nichols, & Stolberg, 2011)

- o Great deal of turmoil; not hesitant to admit to psychological problems; lacks defenses to keep self comfortable; depressed, worried, tense, nervous; may be confused and in state of panic; poor judgment; doesn't profit from experience; introspective; ruminative, overrideational

- o Chronic feelings of insecurity, inadequacy, inferiority; indecisive; lacks socialization experiences; not socially poised or confident; withdraws from social interactions; passive---dependent; can't take dominant role in relationships; difficulties with mature heterosexual relationships; feels inadequate in traditional sex role; sexual performance poor; engages in rich sexual fantasies

- o Neurotic, psychotic, and personality disorder diagnoses equally likely; as Scale 8 becomes greater than Scale 7, likelihood of psychotic diagnosis increases; even when diagnosed as psychotic, blatant psychotic symptoms may not be present

Individuals with this high point pair show chronic personality difficulties characterized by excessive worry, introspection, and overrideational rumination. Passivity is pronounced and difficulty will be encountered in situations

demanding anger, originality, and strength. Dependency is evident in individuals with this high point pair and they suffer from feelings of insecurity, inferiority, and inadequacy. They lack established defense patterns and tend to be

quite nervous around others. A history with few rewarding social experiences is evident, as they lack poise, assurance, and dominance. Judgment is likely to be poor and some confusion evident, as their actions and planning reveal a lack of common sense. Rich fantasy lives are suggested, especially with regard to sexual matters, and they spend much time daydreaming. Serious sexual identity concerns exist as individuals with this high point pair feel inadequate in their traditional sex role and in heterosexual relations. They complain of concentration and thinking difficulties, suffer from excessive indecision, doubt, and vacillation, and may show a formal thought disorder. Psychological interventions are difficult because of the chronic ingrained nature of their conflicts and because of the difficulty in forming interpersonal relationships.

Symptoms and Behaviors

The 78/87 code often occurs among psychiatric patients and reflects a level of agitation sufficiently intense to disrupt their daily activities. Usually, this profile represents a reaction to a specific crisis. They may have been previously functioning at an adequate level until some event or series of events triggered a collapse in their defenses (“nervous breakdown”). Their style of relating to others is passive, and they have difficulty developing and sustaining mature heterosexual relationships. They are lacking in self-confidence, often experience insomnia, and may have hallucinations and delusions. Common feelings include guilt, inferiority, confusion, worry, and fear, and they may have difficulties related to sexual performance.

The extent of elevations on Scales 7 and 8, and the relative heights between them, have important implications both diagnostically and prognostically. If Scale 7 is higher than Scale 8, the person’s psychological condition is more susceptible to improvement and tends to be more benign. This has a tendency to be true regardless of the elevation of 8, as long as 7 maintains its relatively higher position. The higher Scale 7 suggests that the person is still actively fighting his or her problem and has some of his or her defenses still working. It also suggests an anxiety disorder rather than psychosis. Thus, ingrained bizarre thought patterns and withdrawn behavior have not yet become established.

A relatively higher Scale 8, on the other hand, reflects more fixed patterns and is, therefore, more difficult to treat. This is particularly true if Scale 8 is over 75. If Scales 7 and 8 are both greater than 75 (with Scale 8 relatively higher), this suggests an established schizophrenic pattern, especially if the “neurotic triad” is low (check the BIZ/Bizarre Mentation scale). Even if schizophrenia can be ruled out, the condition tends to be extremely resistant to change, as, for example, with a severe, alienated personality disorder. If Scale 2 is also elevated, this raises the possibility of either a dysthymic or obsessive-compulsive disorder.

Personality and Interpersonal Characteristics

Persons with 78/87 code types are likely to feel inferior, inadequate, indecisive, and insecure. Their relationships will often be passive-dependent, and they will have difficulties asserting themselves in heterosexual relationships. They might be preoccupied in excessive and unusual sexual fantasies. They will feel extremely uncomfortable in most social relationships and are likely to defend themselves with excessive withdrawal (check SOD/Social Discomfort scale).

o Ruminative, obsessive, and over-ideational. Intensely self-preoccupied, with convictions of severe impairment and vulnerability, dire expectations, and fears of “going crazy.” Spends much time in fantasy and daydreaming, brooding on guilts and failures, identity concerns, and sexual and morbid themes, with intrusive and alien thoughts, often of violence. Periods of severe distress and panic. Experiences high levels of internal struggle and turmoil with tension, worry, fearfulness, and anxiety; depression, agitation, irritability, and anhedonia. Affect may be flat and isolated. Severe problems with concentration, thinking, and decision making are characteristic. Thought process varies, remaining marginally organized in some patients, although perseveration and periods of confusion, derealization, and depersonalization can occur, and severely disorganized in others with neologisms, clang associations, echolalia, etc. Health concerns and widely distributed somatic complaints, including gastrointestinal, cardiovascular, cardiorespiratory, motor, and sensory symptoms are common. Longstanding feelings of inferiority, inadequacy, and insecurity; severe vulnerability to stress. Feels stressed out and frightened by both internal and external events. Alienation, withdrawal, poor social skills, low self-esteem, and self-consciousness impair relations with others. Fears sudden rejection and losses of support. Interpersonally ambivalent; dependency, passivity, and loneliness are offset by mistrust and apprehensiveness. Look for obsessions and compulsions, psychotic features such as thought disorder, hallucinations, ideas/delusions of reference; suicidal ideation; history of underachievement, family conflict, prior hospitalization, and substance abuse.

7-8 See also the 8-7 combination, p. 211.

1. People with the 7-8 combination tend to be introverted with worry, irritability, nervousness, and apathy present.
2. These people are in a great deal of turmoil and are not hesitant to admit to problems. They have feelings of insecurity, inadequacy, and inferiority; and they tend to be indecisive. They may feel inadequate in the traditional sex role (Graham, 1977).
3. If scale 7 is 10 T-score points higher than scale 8, the tendency is to see anxiety and indecisiveness as the predominant features. If scale 8 is higher than scale 7, the tendency is to see mental confusion as the predominant feature.

4. Long-term counseling is usually necessary.

5. Gynther et al. (1973) have found that psychiatric inpatients with this pattern, 7-8/8-7, may have bizarre speech. Depersonalization also is present at times.

6. Gilberstadt and Duker (1965) have found this 7442-1-3-4) pattern in a VA hospital male population. Scales 1, 2, 3, and 4 are elevated above 70 but are not necessarily the next highest scales after 7 and 8. A man with this profile tended to be shy, fearful, feel inadequate, and have difficulty concentrating. The Gilberstadt and Duker book should be consulted for further information concerning this profile.

7. Adolescents in treatment with the 74/8-7 pattern (Marks et al., 1974) were worriers. They were shy, anxious, and inhibited. Many had deviant thoughts and behavior. The 7 scale does not seem to suppress the 8 scale behaviors as it does for adults. The Marks, Seeman, and Haller book should be consulted for further information concerning this pattern.

8. VA hospital males are excessively introspective, socially maladjusted, and have chronic feelings of anxiety (Hovey & Lewis, 1967).

9. For college clients with this profile, men tended to be introverted, self-conscious, or socially insecure. They were tense, indecisive, and confused. They also had conflicts with their mothers and siblings. Women clients lacked self-confidence, were indecisive and socially insecure. They also were exhausted and nervous (Drake & Oetting, 1959).

10. Kelley and King (1980) have found with the 7-8/8-7 profile in a college client population that males have delusions, flat affect, and an extensive family history of schizophrenia and alcoholism. They were more disturbed than the 7-8-2/8-7-2 males. (See the 7-8-2 combination, below.)

Females, although diagnosed as schizophrenic-latent type as were the males, lacked the overt psychotic features the males showed. In addition to having flat affect and disrupted thought processes, they abused drugs.

7-8/8-7

Patients with this profile code typically show a great deal of turmoil. They do not hesitate to admit to having psychological problems. They lack the defenses to keep themselves comfortable; hence, they are depressed, worried, tense, and nervous. They may be confused and in a state of panic. They have poor judgment and do not profit from experience. They are introspective, ruminative, and overideational.

Chronic feelings of insecurity, inadequacy, inferiority, and indecisiveness are likely to occur. They lack socialization experiences and are not socially poised or confident. They withdraw from social interactions and are passive dependent. They cannot take dominant roles in relationships and have difficulties with mature heterosexual relationships. They often feel inadequate in a traditional sex role; their sexual performance is poor; and they engage in rich sexual fantasies.

Patients with this profile may be diagnosed with anxiety disorder; however, anxiety-based disorder diagnoses decrease, as Scale 8 becomes greater than Scale 7, as the likelihood of psychotic diagnosis increases. Even when they are diagnosed as psychotic, blatant psychotic symptoms may not be present.

78/87 individuals typically are in a great deal of turmoil. They are not hesitant to admit to psychological problems, and they seem to lack adequate defenses to keep them reasonably comfortable. They report feeling depressed, worried, tense, and nervous. When first seen professionally, they may appear to be confused and in a state of panic. They show poor judgment and do not seem to profit from experience. They are introspective and are characterized as ruminative and overideational.

Persons with the 78/87 code type harbor chronic feelings of insecurity, inadequacy, and inferiority, and they tend to be indecisive. They lack even an average number of socialization experiences and are not socially poised or confident. As a result, they withdraw from social interactions. They are passive-dependent individuals who are unable to take a dominant role in interpersonal relationships. Mature heterosexual relationships are especially difficult for 78/87 persons. They feel quite inadequate in the traditional sex role, and sexual performance may be poor. In an apparent attempt to compensate for these deficits, they engage in rich sexual fantasies.

Diagnoses of schizophrenia, depressive disorders, obsessive-compulsive disorders, and personality disorders are all represented among individuals with the 78/87 code type. Schizoid is the most common personality disorder diagnosis assigned to persons with this code type. The relative elevations of scales 7 and 8 are important in differentiating psychotic from nonpsychotic disorders. As scale 8 becomes greater than scale 7, the likelihood of a psychotic disorder increases. Even when a psychotic label is applied, blatant psychotic symptoms may not be present.

Hathaway and Meehl (1951b) found that psychiatric cases with this code were rather evenly divided between neurotic and psychotic diagnoses. The neurotics were obsessive-compulsive, depressive, or, often, showed mixed forms, but few somatization patterns were included. The psychotic cases also ranged widely, although the manic forms were not represented. Depression and introversion were the dominant clinical features, together with worrying, irritability, nervousness, apathy, and social withdrawal. Gilberstadt and Duker included a 78 prototype among their subgroups.

(Dahlstrom, Welsh, & Dahlstrom, 1979)

Description:

Depressive and obsessive-compulsive features, insecure, distressed, socially inadequate, may deteriorate into schizophrenia with neologisms, bizarre speech, depersonalization, catatonic stupor, may be suicidal

Possible Diagnoses:

Borderline p.d., Substance abuse, Brief reactive psychosis, Depression, Obsessive-compulsive dis., Schizophrenia, Schizophreniform dis.

Modifying Scales

- Validity determined by Infrequency (F), Back Infrequency (Fb), and Infrequency Psychopathology (Fp) is relevant, as a random answering of the MMPI-2 results in this profile. High levels of F are not uncommon in valid profiles, given the severity of their panic and damaged self-esteem. However, when Fp is elevated above a T-score of 80 and Dissimulation (Ds) is elevated above a T-score of 80, consider the profile exaggerated. Variable Response Inconsistency (VRIN) above a T-score of 80 would also make the profile invalid.

- When Scale 1 is elevated, look for frightening somatic preoccupations especially if Sensorimotor Dissociation (Sc6) and Neurological Symptoms (HEA2) are elevated. Often, complaints reflect clients' fears that they are damaged, defective, and unlovable.

- When Scale 4 is elevated, the anxiety and alienation associated with the 8-7/7-8 code type would result in episodic, impulsive acting out as a way of reducing dysphoria and tension. Substance abuse, selfmutilation, eating disorders,

passive-aggression, and impulsive tension reduction characterize these individuals. Be alert for suicidal ideation and possible self-destructive tendencies, especially if Scale 4 or Psychomotor Acceleration (Ma2) is elevated.

- When Scale 6 is elevated, the likelihood of a psychotic disturbance with both disordered thinking and paranoid delusions is dramatically increased. In the absence of psychosis, secretiveness, suspiciousness, and preoccupation with others' opinion would be typical.

- Elevations on Scale 9 decrease the social withdrawal and discomfort of 78/87 but would add energy and intensity to the confusion and anxiety inherent in this code type. Periods of hypomania could be likely, with clients exhibiting agitation, confusion, and preoccupation with being a failure. The addition of Scale 9 energizes the profile.

- When Persecutory Ideas (Pa1) is elevated, look for high levels of resentment and a possible paranoid disturbance.

- An elevated Poignancy scale (Pa2) would predict greater interpersonal sensitivity and preoccupation with others' hostility and cruelty.

- Generally, the Schizophrenia (Sc) subscales are all elevated; however, if Bizarre Mentation (BIZ) or Psychoticism (PSYC) is elevated above a T-score of 65—especially if Psychotic Symptomology (BIZ1) exceeds Schizotypal Characteristics (BIZ2), and Aberrant Experiences (RC8) are elevated rule out the possibility of psychotic disorder.

- Typically, the scales Low Self-Esteem (LSE), Anxiety (ANX), Health Concerns (HEA), Social Discomfort (SOD), Obsessiveness (OBS), and Work Interference (WRK) are all elevated, reflecting the social anxiety, difficulties making decisions, poor self-esteem, and general apprehension associated with this profile.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Males

Low 0 Introverted or self-conscious or socially insecure, one interview only, nonresponsive or nonverbal, tense, indecisive, lacks knowledge or information, vague goals, confused, aggressive or belligerent.

- Note: Scale 0 coded low was infrequently associated with introversion or self-consciousness or social insecurity, being nonresponsive or nonverbal, indecisiveness.

Low 1/2/3/4/5/6/9 Introverted or self-conscious or socially insecure, nonresponsive or nonverbal, tense, indecisive, lacks knowledge or information, vague goals, confused.

Nothing Low Introverted or self-conscious or socially insecure, lacks skills with the opposite sex, mother conflict, sibling conflict, nonresponsive or nonverbal, tense, indecisive, unhappy, worries a great deal, insomnia, lacks knowledge or information, vague goals, confused.

Females

Low 0 - Insomnia, nervous, lacks self-confidence, verbal.

Note: Scale coded low was infrequently associated with lack of self-confidence.

78-1 Insomnia, nervous, lacks self-confidence.

78-2 Insomnia, nervous, lacks self-confidence.

Note: Scale 2 coded low was infrequently associated with lack of self-confidence,

78-3 Insomnia, nervous, lacks self-confidence, cried in the interview.

78-4 Insomnia, nervous, lacks self-confidence.

78-5 Insomnia, nervous, headaches, exhaustion, anxieties, lacks self-confidence, indecisive, socially insecure, distractible in study.

78-6/9 Insomnia, nervous, lacks self-confidence.

78-X Insomnia, headaches, nervous, exhaustion, depressed, lacks self-confidence, father conflict, mother conflict, sibling conflict, 8+ conferences, lacks skills with the opposite sex

(Drake & Oetting, 1959)

o **Check:** *CogProb, DisOrg, ANX, FRS1, OBS, RC7, DEP1, DEP2, DEP3, DEP4, HEA2, BIZ1, BIZ2, ANG1, ANG2, CYN1, CYN2, LSE1, LSE2, SOD1, SOD2, FAM1, FAM2, PSYC, DISC, NEGE, Dr1, Dr4, Dr5, Hy1 (low), Hy2 (low), Hy3, Hy4, Hy5 (low), Pd1, Pd3 (low), Pd4, Pd5, Pa1, Pf1, Pf2, Pf3, Pf4, Pa2, Pa3, Sc1, Sc2, Sc3, Sc4, Sc5, Sc6, Si1, Si2, A, R, Re (low), GM (low), AAS, MDS.*

TREATMENT

These individuals generally have low motivation to seek treatment and doubt its efficacy for them, so engaging them in treatment can be difficult. Look for childhood histories of having been teased or put down, sexually abused, or experiencing some traumatic blows to their self-esteem. Some were slow to mature, which may have made them vulnerable to being teased or put down. Some may have been sickly as children and consequently felt vulnerable. Many currently experience health preoccupations and worries, perhaps reflecting a general fear that there is

something seriously wrong with them. Others may have been food finicky as children, or exhibited other personal eccentricities which left them vulnerable to being teased or humiliated by siblings and peers.

If Scale 4 is coded third, the sense of alienation is increased, as is the likelihood of impulsive, self-defeating acting out to reduce tension. Young 78/87 adults experience difficulties in college because of low self-esteem and ambivalence about emancipating from a home where they were both infantilized and humiliated by their lack of self-efficacy. Therapy should involve self-esteem building by nurturing therapists who encourage the patient to take small interpersonal risks once they have earned the patient's trust. Insight therapy tends to be disorganizing as they are self-critical and view insight as a confirmation of being "damaged goods." The 78/87 individual anticipates the therapist will take the role of an involved, caring parent who is both controlling and disappointed with them. Often they are immobilized in the therapy session, unable to collect and articulate coherent thoughts. They see themselves as defective and over-idealize the therapist. Self-revelation of personal frailties by the therapist can help the patient understand that most people experience vulnerabilities. Suicidal ideation is common. Psychopharmacologic intervention is often necessary to address their intense agitation and thought fragmentation. Assertiveness training, relaxation training and thought stopping to help manage their constant sense of panic can be useful.

o **Treatment:** Rule out Schizophrenia; mood disorder; Obsessive-Compulsive Disorder or other anxiety disorder; Schizotypal, Compulsive, or Dependent Personality Disorder. Risk of impulsive suicide. Biological treatments more effective than psychotherapy to improve symptomatic status and reduce suicide risk. Antidepressants may precipitate mania. Supportive and cognitive therapies are effective in the post-acute phase, as are social skills and assertiveness training. Motivated for symptomatic relief; introspective; insight often well-preserved (except in schizophrenia). Accepts and benefits from structure, support, and reassurance. Psychotherapy is often helpful after initial difficulties in gaining rapport are overcome.

- With elevated 2: dysthymic or obsessive-compulsive disorder.
(Groth-Marnat, 2009)

Treatment Implications

There may be a significant suicidal risk, which can be further evaluated by looking at the relative elevation of Scale 2, checking relevant critical items, taking a careful history, and asking relevant questions related to the client's thought processes.

Therapy and Therapeutic Pitfalls

Point out that these individuals' sensitivity can be viewed as a strength, although it may currently be causing them distress. These clients feel inadequate, insecure, and fearful, so it is important to recognize that therapist insights have the potential to confirm their negative self-esteem. They are ruminative and overideational, so analysis and insight therapy tend to be disorganizing. Warm, empathic, but structured approaches are helpful to establish therapeutic rapport. Dealing with transference on an ongoing basis is important, as there is a tendency to see most interactions as confirming of their negative self-image. Often, medication is necessary to lower anxiety and panic, but it needs to be monitored, as individuals with this code type are sensitive to side effects. Be alert for suicidal ideation and possible self-destructive tendencies, especially if Ma2 and Scale 4 are moderately elevated. In the presence of a history of mood disorders in the client or their relatives, antidepressants may precipitate a manic episode and increase suicidal ideation. (In some cases, the clients' depression is secondary to severe anxiety and low self-esteem.)

Once clients trust the therapist, they are amenable to cognitive-behavioral therapy. During history-taking, help them develop empathy for themselves as eccentric or sensitive children. Therapy that combines insight, empathy, and coaching interpersonal and self-soothing skills are useful. These clients need to learn self-efficacy to help manage stress without panicking. Social skills training (Corrigan, 1991), thought stopping, cognitive-behavioral techniques (McKay & Fanning, 2000), schema therapy (Young, 1999), and systematic desensitization for specific phobias (McGlynn et al., 2004) can also be helpful. Assertiveness training, and helping the clients realize that anger will not necessarily lead to abandonment, can increase their social comfort. (Levak, Siegel, Nichols, & Stolberg, 2011)

Treatment and Self-Help Suggestions

1. If your internal world is frightening, if you're feeling paranoid or you're hearing voices, talk to your therapist about possible medication. While you might be apprehensive about it, medication can help calm down your inner world so that you can think more clearly. It is important that you and your therapist talk openly about any uncertainty or concerns you have.¹
2. Discuss with your therapist your current situation to see what may have triggered your sense of panic and low self-esteem. Have you been concerned that someone could be judging you, putting you down, or humiliating you? Have you had a recent loss or setback that has left you feeling defective and damaged?
3. Talk to your therapist about any childhood memories where you had been humiliated and put down. Try to revisit those situations with your therapist, understanding how your responses were normal and adaptive

and that your early sensitivity was a valuable trait that others did not understand. Attempt to develop some empathy for yourself as a child.

4. Work with your therapist to see if you can identify any beliefs or themes that you developed in dealing with difficult childhood experiences.² Some common themes include the expectation that people will hurt or humiliate you, the belief that others will take advantage of you, or that you are unlovable or damaged. Being able to express the emotions in the safety of the therapy setting can gradually help you learn new perspectives and challenge these old belief systems.³
5. Whenever you panic about a mistake you've made, try to stand back and think of a calm, relaxing scene. This type of observing called "mindfulness" involves paying attention to the present moment in a nonjudgmental way, fostering a quality of curiosity and openness.⁴ For more information on mindfulness exercises see www.mindfulnessstapes.com. Engaging in a daily practice of mindfulness can help you manage powerful emotions.⁵
6. Learn to express anger as you feel it. Try to be more assertive and to ask for what you want. You'll find that people can respond well. Work with your therapist to learn how to speak up for yourself. Your therapist can help you begin to be more assertive by teaching you techniques such as "I" statements that let a person know how you feel in a nonjudgmental way. A good book about assertive techniques is *When I Say No I Feel Guilty* (Smith, 1975).
7. Avoid chemical agents as a way of medicating your anxiety; it will tend to aggravate your difficulties with concentration, memory, and effective reality testing. Collaborate with your therapist to weigh the pluses and minuses of making changes in your lifestyle.⁶
8. When you feel panicked and unable to get anything done, make a list of a few priorities and then do them one after the other without interrupting yourself. Fill out the "Daily Hassles and Stress" form (<http://www.scribd.com/doc/7156530/Daily-Hassles-and-Stress-Scale>), which can help you identify sources of stress in your life. You and your therapist can then address specific "hassles" (e.g., "Unwanted interruptions at work," or "Not enough leisure time") that may contribute to your symptoms.⁷

9. Learn to stop your thoughts when they begin to get out of control. Work with your therapist to identify some of the most distressing and negative “intrusive” thoughts that you have. “Thought stopping” is an effective technique you can practice to help you prevent the types of unwanted thoughts that can make you feel anxious. Several forms of thought stopping are effective. One quick technique involves picturing or saying out loud, “Stop,” whenever you experience these types of unwanted thoughts. You then replace the thought with a pleasant image or affirmation that is more positive (e.g., “I have felt this way before, and I know I can handle this”).
10. See if you can become aware of negative, self-critical thoughts where you tell yourself that you are unlovable or somehow defective. This type of harsh self-judgment can cause a great deal of pain. Work with your therapist on ways to increase your self-esteem.⁸ There are a number of good techniques, including personal wellness, setting goals, self-expression, looking at “core beliefs,” and monitoring your “self-talk.”

¹ Compliance therapy combines principles of motivational interviewing, inductive questioning, reflective listening, and reinforcing adaptive behaviors and attitudes to explore client ambivalence and target medication adherence (Kemp, David, & Hayward, 1996).

² Schema therapy has been demonstrated to be an effective treatment for clients who expect and anticipate emotional rejection and criticism based on their own early childhood conditioning experiences. Help clients first identify their particular schema (Bricker & Young, 2004), and then work to help them examine the early experiences that led to that belief. The next step is to challenge that idea and to help them examine whether it is true and whether it is helpful (Young, Klosko, & Weishaar, 2003).

³ Schema therapy uses many of the same methods of cognitive behavioral therapy, but it adds imagery to uncover suppressed emotions and to highlight the ways that these fixed beliefs affect current relationships (Young, 1999).

⁴ Bishop et al. (2004) explain mindfulness as an acceptance of the present moment and a playful and curious awareness.

⁵ Mindfulness and compassion can play a powerful role in helping people who have traumatic backgrounds and perceived threats either from the external world (what others might do to them) or from their internal feelings of being overwhelmed by self-contempt or troubling memories (Gilbert & Tirch, 2009). Orzech, Shapiro, Brown, and McKay (2009) studied the role of intensive mindfulness training on changes in psychological symptoms and found significant increases in well-being, self-compassion, and resilience, and decreases in anxiety after 1 month of mindfulness training.

⁶ Motivational interviewing (MI) has been demonstrated to be an effective approach for raising problem awareness and facilitating change in clients who may be resistant, ambivalent, stuck, or not yet “ready” to make general behavioral changes and changes in drinking behavior in particular (Burke, Arkowitz, & Menchola, 2003; Miller & Rollnick, 2002). MI is particularly effective for people in the early stages of

change, who are sensitive to being lectured and resent feeling forced to take action. General information can be found on the motivational interviewing homepage (www.motivationalinterview.org).

⁷ Findings have shown that clients who had more daily hassles as reported on the “Daily Hassles” form experienced more psychological health problems (Bottos & Dewey, 2004; DeLongis, Coyne, Dakof, Folkman, & Lazarus, 1982). The “Daily Hassles and Stress” form can be found on the Web site mentioned in the text (Kohn & MacDonald, 1992).

⁸ Whereas some studies find that positive affirmations are helpful (Philpot & Bamburg, 1996), others have found them to be neutral to harmful for those with very low self-esteem (Wood, Perunovic, & Lee, 2009). For situational low self-esteem, cognitive techniques and affirmations can help change maladaptive patterns, but for characterologically low self-esteem the emphasis should be on negative core beliefs, maladaptive schemas, and the development of self-compassion (McKay & Fanning, 2000). (Levak, Siegel, Nichols, & Stolberg, 2011)

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you feel a constant sense of anxiety, worry, and dread, as if something terrible is about to happen. You feel self-critical and constantly guilty, as though you have done something terrible and are a condemned person. Often people with your profile grew up in environments experiencing teasing, put downs, or other unpredictable humiliations. You adapted to these events by staying constantly on guard and being careful to not allow others too close to you, lest they discover your weaknesses and exploit them to humiliate you. At times, your mind may feel as if it has a will of its own, and negative, disturbing thoughts feel as if they are invading you. It is easy to feel that others are looking at you critically and judging you, and even around strangers you likely feel sure people are feeling negatively toward you. Concentrating, remembering things, and making decisions are probably hard for you because you experience too many thoughts at once. Using a computer analogy, it is as if your mind has “too many windows” opened at once. At times, you may feel so confused that it is hard to know whether your worries and preoccupations are realistic, or if you are overblowing them. Your therapist may want to suggest medicine to help you feel a little calmer, think more clearly, sleep better, and not feel as vulnerable and unsafe. You may feel discouraged about therapy, perhaps feeling too vulnerable to open up and talk about how you are feeling. You may feel ashamed of some of your thoughts and feelings. Discuss with your therapist if you feel criticized or judged by the therapeutic experience. Talk to your therapist if you feel suicidal and plan to kill or harm yourself.

Feedback Statements—Elevated Profiles (T-Score > 65)

Strengths

Your profile reveals that you have a number of strengths. You are an analytical, thoughtful, sensitive individual who can be creative and unconventional in the way that you see the world. Generally, you are detail oriented; you are not pushy, bossy, or demanding, and you tend to be cautious about hurting other people's feelings.

Anxious or Paranoid

Currently, however, you are experiencing internal distress, and much of the time you live with a sense of anxiety and dread. Even in moments when things are going well, it's hard for you to relax, to switch off your mind, and to stop ruminating. You worry that, at any moment, something you do or say will lead to catastrophe. In some cases, people with your profile can feel so sensitive to criticism and judgment that they actually feel paranoid. Perhaps you feel that others are looking at you critically, or you imagine that people are out to punish or embarrass you. Sometimes your internal thoughts can become so loud that you actually hear them as voices talking to you. This reflects how anxious, tense, and insecure you feel.

Overly Analytical or Self-Critical

You are an analytical person, but lately you are examining everything you say or do in a negative light. It's hard for you to make decisions because you see every side of an issue, and you're afraid that if you make the wrong choice things will go badly and you will be rejected. You tend to be your own worst critic; even when people give you compliments it's hard for you to trust that they mean it. Sometimes your negative self-image can be so extreme that you feel you are broken, damaged, and hopelessly unlovable.

Somatic Complaints

You get so tense from worry that your body takes a strain, so you may have physical symptoms of stress. These physical symptoms—such as headaches, backaches, numbness, tingling, or other sensations—frighten you, and you have a tendency to catastrophize, feeling that there is something very wrong with you.

Rich Fantasy Life

Although you have a rich fantasy world, sometimes you may find yourself thinking about mostly negative things. As a way of escaping from your painful reality, you may develop your own view of religion or politics and your own way of looking at the world. Being sexual is probably scary for you because it involves getting close to people, and you may avoid close relationships and instead have sexual fantasies. Some of your fantasies may frighten you.

Difficulties Expressing Anger

If anyone is critical of you, it's easy for you to feel defective and to assume that you are a complete failure. It's hard for you to get angry with people, and you doubt that you have the right to do so; you often worry, ruminate, and obsess about how to express your frustration. You probably let these frustrations build, perhaps having angry fantasies about the person who has upset you.

Guilt Prone, Difficulty With Memory and Concentration

Guilt is a constant companion. If you make a mistake, it's easy for you to feel you are a bad person and then to create all sorts of catastrophic scenarios in your mind about what's going to happen because you erred. Living with this sense of dread and fear make it hard for you to concentrate and to remember things. You'll find yourself somewhat inefficient, unable to make decisions, to get things done, or to "log in" important information.

Responsible, Dutiful, Procrastinates

Although you try to be responsible and dutiful, you may procrastinate. Sometimes people with your profile can't move into action because they see every side of an issue, and they're afraid to move forward for fear of making a mistake. Even basic chores feel overwhelming because you worry about doing them the right way. Sometimes the anxiety can be so high that you run around in circles, beginning projects without ever completing them.

Self-Conscious

It might make you uncomfortable to be praised, perhaps out of fear that if you enjoy praise it will somehow be taken away from you. Reaching out to people is probably frightening because you assume that others won't like you. Being around people can make you very self-conscious so that you feel as if you're in a movie, observing yourself and unable to let go and be spontaneous.

Lifestyle and Background Feedback

Often, people with your profile grew up with parents who were unpredictably explosive and, perhaps, humiliating and rejecting. At times they may have wanted to protect you, but you likely felt embarrassed by their attention. An adaptive way to deal with such a situation was to stay alert, trying to anticipate the next putdown. You probably spent a great deal of time as a child thinking about how to avoid shame and rejection, analyzing your responses to avoid disappointing others. You also may have been a sensitive child whose feelings were easily hurt. You may have been shy and nonassertive. As a child, you might have been quick to cry or perhaps slow to warm up to others. Sensitive children are more likely to be teased by their siblings and peers. If your parents were supportive and saved you, you might have experienced it as disgraceful.

Normal-Range Feedback (T-Score 50 to 65)

Your profile is in the normal range and reveals that you have a number of strengths. You are an analytical person who looks at problems in a creative and unusual way. You are aware of details and cautious about making mistakes.

You take life seriously, feel responsible when things go wrong, and hate to disappoint people. Guilt is a familiar feeling, and you hate to displease people or make them angry. Generally, people with your profile are cautious about getting angry and confronting others. It's hard for you to relax and enjoy your successes and accomplishments. Although your profile is within the normal range, you may be prone to periods of anxiety where you overanalyze events, as if to protect against something unpredictable happening. You dislike risks, and you expend energy making sure that no unforeseen detail could lead to you feeling humiliated or bad about yourself. (Levak, Siegel, Nichols, & Stolberg, 2011)

782 Code

1. Kelley and King (1980) found the 7-8-2/8-7-2 profile group in a college client population had different descriptors depending upon the sex of the client. Males in this group had many features in common with 74/8-7 males. Both code types had depression, interpersonal problems, and at least one physical complaint. They also had disrupted thought processes, ideas of reference, suicidal ideations, and obsessions. They were typically diagnosed as schizo-phreniclatent type. The 7-8-2/8-7-2 males in addition had social withdrawal.
2. Females were less disturbed than the males. They only had interpersonal problems and suicidal ideation. Their most likely diagnosis was adjustment reaction.

789 Code

Males

Low 0 Introverted or self-conscious or socially insecure (78), home conflict, one interview only, nonresponsive or nonverbal (78), tense, indecisive (78), lacks knowledge or information, vague goals, confused, lacks academic motivation, aggressive or belligerent, defensive. This pattern was infrequently associated with introversion (9-0), shyness in the interview, being nonresponsive or nonverbal (9-0), being nonverbal or a nonrelator, indecisiveness (9-0).

Low 1/2/3/4/5 Introverted or self-conscious or socially insecure, home conflict, nonresponsive or nonverbal, tense, indecisive, lacks knowledge or information, vague goals, confused, defensive.

- Note: Scale 9 coded high was infrequently associated with being nonresponsive or nonverbal and indecisiveness.

Low 6 Introverted or self-conscious or socially insecure, home conflict, nonresponsive or nonverbal, tense, indecisive, lacks knowledge or information, vague goals, confused, rationalizes a great deal, defensive.

- Note: Scale 9 coded high was infrequently associated with being nonresponsive or nonverbal and indecisiveness.

Nothing Low Introverted or self-conscious or socially insecure, lacks skills with the opposite sex, home conflict, mother conflict, sibling conflict, nonresponsive or nonverbal, tense, indecisive, unhappy, worries a great deal, insomnia, lacks knowledge or information, vague goals, confused, defensive.

- Note : Scale 9 coded high was infrequently associated with being nonresponsive or nonverbal, indecisiveness, worrying a great deal, lack of skills with the opposite sex.

Females

Low 0 - Insomnia, nervous, restless, exhaustion, lacks self-confidence, confused, 8+ conferences, verbal, resistant in the interview, sibling conflict, distractible in study, marriage oriented, socially extroverted.

- Note: Scale 0 coded low was infrequently associated with exhaustion, lack of self confidence, confusion, sibling conflict.

Low 1 - Insomnia, nervous, restless, lacks self-confidence, confused, 8+ conferences, verbal, resistant in the interview, sibling conflict, distractible in study, vague goals, socially extroverted.

- Note: Scale 1 coded low was infrequently associated with sibling conflict.

Low 2 - Insomnia, nervous, restless, exhaustion, lacks self-confidence, confused, 8-|- conferences, verbal, resistant in the interview, sibling conflict, distractible in study, socially extroverted.

- Note: Scale 2 coded low was infrequently associated with lack of self-confidence and confusion.

Low 3 - Insomnia, nervous, restless, lacks self-confidence, confused, 8+ conferences, verbal, resistant in the interview, cried in the interview, sibling conflict, distractible in study, vague goals.

Low 4 - Insomnia, nervous, restless, lacks self-confidence, confused, 8+ conferences, verbal, resistant in the interview, nonresponsive, sibling conflict, distractible in study, shy in the interview.

- Note: Scale 9 coded high was infrequently associated with shyness in the interview.

Low 5 Insomnia, nervous, restless, headaches, exhaustion, anxieties, lacks selfconfidence, confused, indecisive, 8+ conferences, verbal, resistant in the interview, wants answers, sibling conflict, distractible in study, socially insecure.

- Note: Scale 5 coded low was infrequently associated with resistance in the interview.

Low 6 - Insomnia, nervous, restless, lacks self-confidence, confused, 8+ conferences, verbal, resistant in the interview, sibling conflict, distractible in study.

Nothing Low - Insomnia, nervous, restless, headaches, depressed, exhaustion, lacks self-confidence, confused, 8+ conferences, verbal, resistant in the interview, sibling conflict, father conflict, mother conflict, distractible in study, lacks skills with the opposite sex.

(Drake & Oetting, 1959)

79/97 Codes

This relatively uncommon codetype often has Scales 8 or 4 as the next highest scales. It reflects an individual who is compulsively preoccupied with success and avoiding failure. The combination of Scale 7 anxiety, guilt, and apprehension is energized by hypomanic traits. In some ways, the scales are contradictory, since Scale 7 suggests insecurity, guilt, apprehension, and a lack of self-confidence while Scale 9 predicts grandiosity, overcommitment, and a buoyant self-confidence. 97/79 individuals are constantly on edge, preoccupied with avoiding loss, and maximizing rewards. They tend to be obsessive, driven, impulsive, and excitable. They are talkative, if not garrulous, and tend to switch topics readily in response to feedback from others. Some may experience somatic symptoms reflecting internal tension. Muscle spasms, backaches, insomnia, and disturbed sleep are typical. Reflecting Scale 7 and 9 traits, these individuals can present as fearful and panicked about an impending failure or loss and, at the same time, exhibit unrealistic optimism and grandiosity. They feel guilty about perceived past failures, and can exhibit both meticulous attention to detail as well as impulsiveness and procrastination. Highly overactive, 97 individuals tend to commit to too many tasks and activities. Impulsive behavior may lead to self-recriminating guilt. They are highly sensitive to being controlled. In some cases, the profile may reflect the hypomanic phase of a bipolar disorder.

They exhibit conflict in intimate relationships, seek reassurance and are dependent, but at the same time resent being controlled.

o **Definition:** An unusual and unstable profile. May be found in patients with Bipolar Disorder or patients who may be seeking to distract themselves from some kind of real or impending setback.

o Compulsive achievement strivings. Tense, apprehensive, and over-reactive to security threats; very threatened by failure. Anxious, agitated, and obsessive, but driven, impulsive, and excitable. Emotionally and behaviorally under-controlled and impulsive. Somatic complaints such as musculoskeletal symptoms, sexual problems, and disturbed sleep may represent effects of chronic tension and stress. May be at once fearful or panicky about impending failure or catastrophe, and unrealistically optimistic about success. May obsess about past failures and future triumphs, and shift from meticulousness to recklessness. Overactivity, when present, is pressured and forced rather than natural and euphoric, and is often closely focused on a specific project or issue. Concentration and memory are only mildly impaired, but judgment may be poor and dominated by impulse. Mild psychotic or schizotypal features such as intrusive and disruptive thoughts and suspiciousness may be present. Both intro-punitive and extro-punitive. Intolerant of boredom and others' demands. Seeks stimulation as a distraction from subjective distress. Conflicted about dependency. Threatened by disapproval and rejection. Egocentric and immature; may be thoughtless and unkind toward others, eventually driving them away. Look for history of mood disorder, substance abuse, or both; family conflict; and periods of impulsive and heedless action followed by periods of guilt, remorse, and self-condemnation.

1. A person with a 7-9 combination tends to present many unconnected thoughts and talks compulsively about them.
2. These people may alternate between grandiosity and self-condemnation (Hovey & Lewis, 1967).
3. Adolescents in treatment with the 7-9/9-7 pattern (Marks et al., 1974) were seen as worrying and vulnerable to threatreal or imagined. They were basically insecure and had strong needs for attention. At the same time, they were conflicted over emotional dependency. The Marks, Seeman, and Haller book should be consulted for further information concerning this pattern.
4. Kelley and King (1979a) found the 7-9/9-7 code type primarily for men in their college counseling center population. Males with this code type had lost weight, were tense, nervous, and suspicious. Their judgment was poor and their thoughts disrupted. They were typically diagnosed as schizophrenic.

Male

Low 0 Home conflict, defensive, aggressive or belligerent, lacks knowledge or information, one interview only.

This pattern was infrequently associated with introversion or self-consciousness or social insecurity, shyness in the interview, being nonresponsive or nonverbal, being nonverbal or a nonrelator, indecisiveness.

Low 1/2/3/4/5 Home conflict, defensive.

Low 6 Home conflict, defensive, rationalizes a great deal.

Low 8 Home conflict, defensive.

Nothing Low Lacks skills with the opposite sex, home conflict, mother conflict, sibling conflict, nonresponsive or nonverbal, tense, indecisive, unhappy, worries a great deal, insomnia, confused, defensive.

- Note: Scale 9 coded high was infrequently associated with being nonresponsive or nonverbal, indecisiveness, worrying a great deal, lack of skills with the opposite sex.

Female

Low 0 - Nervous, exhaustion, confused, verbal, sibling conflict, distractible in study, marriage oriented, socially extroverted.

- Note: Scale coded low was infrequently associated with exhaustion, confusion, sibling conflict.

Low 1 - Nervous, confused, sibling conflict, distractible in study, vague goals, socially extroverted.

- Note: Scale 1 coded low was infrequently associated with sibling conflict.

Low 2 - Nervous, confused, sibling conflict, distractible in study, socially extroverted.

- Note: Scale 2 coded low was infrequently associated with confusion.

Low 3 - Nervous, confused, cried in the interview, sibling conflict, distractible in study, vague goals.

Low 4 - Nervous, confused, nonresponsive, sibling conflict, distractible in study, shy in the interview.

- Note: Scale 9 coded high was infrequently associated with shyness in the interview.

Low 5 - Nervous, headaches, insomnia, exhaustion, anxieties, confused, indecisive, lacks self-confidence, verbal, sibling conflict, distractible in study, socially insecure.

Low 6/8 - Nervous, confused, sibling conflict, distractible in study.

Nothing Coded Low - Nervous, headaches, confused, sibling conflict, distractible in study.

(Drake & Oetting, 1959)

o **Check:** *ANX, OBS, DEP1, DEP2, DEP3, BIZ1, BIZ2, ANG1, ANG2, CYN2, TPA1, TPA2, LSE1, LSE2, SOD1, SOD2, AGGR, PSYC, NEGE, RC7, Dr1, Dr2 (low), Dr4, Dr5, Hy2 (low), Hy3, Hy5 (low), Pd4, Pd5, Pa1, Pf1, Pf2,*

Pf3, Pf4, Pa2, Pa3 (low), Sc1, Sc2, Sc3, Sc4, Sc5, Sc6, Ma1, Ma2, Ma3, Ma4, Si1, Si2 (low), A, R (low), Re, MAC-R, APS, AAS, MDS.

TREATMENT

The central issue is a profound fear of failure and disapproval. Look for childhood conditioning experiences of parents who were constantly motivating the child to be more successful but quick to criticize their efforts when they viewed them as inadequate. In other cases, early economic deprivation may have resulted in the adoption of a constant high drive state, always seeking to maximize rewards and avoid failure. These individuals have a strong need to prove themselves. They tend to be defensive, both extolling their own virtues and preemptively protecting against criticism by exaggerated self-criticism. They oscillate between grandiosity and self-negation.

Treatment should focus on helping them define their own goals rather than internalized parental expectations.

Relaxation training and thought stopping can be useful to control the severe anxiety and panic attacks. Implosion therapy can help engage their “worst fears” around failure, and being rejected and shamed because of it.

o **Treatment:** Rule out Bipolar Disorder, Mixed or Manic, Cyclothymia, and obsessive-compulsive features. Risk of impulsive suicide. May be amenable to a variety of treatments, including biological measures (e.g., mood stabilizers), behavioral and skills training procedures (e.g., assertiveness training and anger management), and conventional psychotherapy. Consider retesting after an interval of observation and change in mental status as a guide to treatment.

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you are an extremely energetic and driven individual. You seem to work in bursts of energy, letting things pile up and then getting them done in a whirlwind of activity. Your profile also suggests that you experience periods of intense anxiety, usually centered on the pursuit of your goals. It is as if you are constantly on edge, trying to anticipate any small detail that could rob you of obtaining the maximum reward from any situation. You may experience a sense of urgency, constantly feeling like you’re running late or are behind, and that somehow you have to achieve great things in order to feel lovable and worthy. If people keep you waiting or get in your way when you’re focused on a task, you can become quite irritable and angry. Others may find being around you difficult because of your high energy and constant sense of anxiety. You may find yourself explaining yourself to

others, sometimes talking too much or interrupting others, because “you know what they are going to say.” Sometimes your mind can work quickly and you see all the connections between things, but it is hard to make a decision. Consequently, you may exhibit both compulsive and perfectionist traits and, at the same time, have areas of your life with many loose ends because you can’t decide what “the perfect solution” should be. People with your profile sometimes grew up in environments where parents constantly motivate, but do not reward successes. In others cases, people with your profile grow up in environments where they were often frustrated in getting their needs met. You adapted by going on “full speed ahead” mode, constantly trying to maximize everything you do and trying to avoid the slightest setback or failure. As a result, the world moves too slowly for you, as if you’re driving a sports car in rush hour traffic with one foot hard on the accelerator and the other foot hard on the brake. No wonder you experience a lot of internal tension that can result in physical symptoms of stress. Work with your therapist to determine what you want out of life, and make sure that you identify your own goals versus goals that you think will please others. Discuss with your therapist childhood events that exemplify how you felt constantly pressured to achieve and succeed, and to avoid frustration and failure. Avoid overcommitting to too many tasks and activities. Watch your tendency to talk too much in social situations, and take some mindfulness classes to learn how to recognize when anxiety and stress are building. Find exercise programs that can help you relieve daily stress, which may improve your sleep patterns. Learn to control your anxiety by focusing on being “in the moment,” rather than always thinking many steps ahead. Allow yourself to enjoy some of your past successes rather than constantly focusing on future ones.

70/07 Codes

(see also Scales 7 and 0)

This is an uncommon codetype, with Scale 2 or 8 as the most commonly occurring third highest scale. It is useful to examine the two-point codetype that would result if Scale 0 were temporarily not included.

Individuals with these elevations are shy, worried, tense, and feel inadequate, especially socially. They feel insecure about their physical appearance. They tend to be obsessively self-critical, brooding, and experience difficulties with memory and concentration. The combination of scales suggests extreme social anxiety, as genetic introversion is aggravated by severe anxiety and self-doubt. These individuals lack confidence, are indecisive, and ruminate about their inadequacies. They often feel guilty, especially at the expression of anger toward others. Physical symptoms of anxiety are also common, and they may experience low energy levels in spite of feeling agitated. Even if Scale 2 is not elevated, they report feeling dysphoric. They report feeling constantly on edge, as if anticipating disaster, and are stung by minor criticism, taking setbacks badly. Problems with attention and concentration as well as difficulty in

making decisions are typical. Although they gravitate toward responsibility, they are readily overwhelmed by it. Extremely shy and self-conscious, these individuals are easily embarrassed and may become “tongue-tied” in unstructured social situations. Sleep difficulties are common. While some can be obsessive, compulsive, and perfectionistic, others are unable to make decisions and tend to procrastinate.

o Anxiety and dysphoria with inhibition, indecision, inertia, severe self-consciousness, lack of self-confidence, passivity/dependency, and extreme interpersonal sensitivity. Socially timid/avoidant. Overcontrolled. May be preoccupied about physical appearance or fears of unattractiveness. Check third highest scale.

1. Although this pattern is uncommon, when it is present, the person has a serious generalized social inadequacy (Lachar, 1974).
2. Adolescents in treatment with the 7-0/0-7 pattern (Marks et al., 1974) were typically referred because of shyness and extreme sensitivity. They tended to blame themselves excessively and were over-controlled. The Marks, Seeman, and Haller book should be consulted for further information concerning this pattern.
3. Social problems are found in college students with the 7 and 0 scales as the two highest points in a profile (Drake & Coating, 1959).
 - a. These students tend to be non-verbal and lack confidence and social skills.
 - b. College counselors rate these clients as "shy."
 - c. They also are tense, confused, worry a great deal, and suffer from insomnia.

Description:

Tension, insecurity, anxiety, low self-confidence, interpersonal difficulties

Possible Diagnoses:

Anxiety dis-s, Agoraphobia, Avoidant p.d.

TREATMENT

Look for a childhood history of life-long shyness, with resulting fears of being teased or humiliated. Thought stopping, relaxation training, meditation, an exercise program, self-esteem building, and social skill building can all be helpful. Mindfulness therapy can be helpful to recognize when they are experiencing overloads of stress and irritability, so they can learn to be expressive and manage their feelings with self-soothing techniques.

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you are a shy person and have probably been shy most of your life. You are also a dutiful, responsible, and prone to worry individual who takes life seriously. Your profile suggests that you tend to be your own worst critic and that you are self-critical in almost all areas, even your appearance. Perhaps growing up shy you have always felt a little vulnerable in social situations. In unstructured social situations you may find yourself becoming “tongue-tied,” unable to engage in small talk. Because you are prone to worry, you feel overwhelmed as responsibilities accumulate. You focus on your failures and defeats, and it is hard for you to celebrate your accomplishments. No matter how well you do at something, you can always see how it can be done better and you have a tendency to brood and ruminate about past events, criticizing yourself because you think you could have done things better. It is often hard for you to make decisions because you’re afraid of the resulting guilt if you feel you made a poor one. You tend to see the negative side of most issues, so sometimes you procrastinate, feeling paralyzed by all the possibilities and the things that can go wrong. People with your profile may experience periods of panic, and at times develop certain compulsions and obsessions, perhaps as a way of trying to reduce their anxiety. Growing up you may have felt fearful of being teased because of your shyness. You may have experienced unpredictable negative events that were traumatic, which led you to adapt by constantly trying to protect yourself against future setbacks. Work with your therapist on social skill building so you can learn to make small talk when appropriate. Work at being less self-critical. Take a mindfulness class to learn how to enjoy being in the moment and avoid looking at past events in a self-critical manner. Learn to recognize when anger is building, and rehearse ways to express it so that you do not feel guilty. Talk to your therapist about concerns you may have about therapy and feeling discouraged about the process even before you begin.

Scale 8: Schizophrenia (SC)

Descriptors

Complaints

Anxiety, confusion, identity disturbance, alienation, dysphoria, anhedonia, disorganized, possible psychotic episodes, damaged identity, low self-esteem, work and relationship difficulties, sexual concerns, preoccupation with rejection and humiliation, sometimes hostile and inappropriate behavior, somatic complaints, difficulties with memory, judgment, or concentration, possible hallucination or delusions, diffuse paranoia

Thoughts

Idiosyncratic, disorganized, cognitive slippage, preoccupied with esoteric and sometimes bizarre and sexual or hostile themes or fantasies, poor concentration, memory, or judgment, poor reality testing, possible delusions and hallucinations, confused, disoriented, indecisive

Emotions

Anhedonia, hopeless, helpless, periods of panic, lacking in empathy, depersonalized, derealized, cold, emotionally indifferent, feeling broken, damaged, or unlovable, outbursts of rage or hostility

Traits/Behaviors

Schizoid, possibly psychotic, immature, eccentric, socially withdrawn, isolated, or reclusive, confused, uninvolved, alienated, apathetic, unkempt, self-defeating, self-protectively withdrawn,

(Levak, Siegel, Nichols, & Stolberg, 2011)

Therapist's Notes

Individuals who fall within a range T-Score of 50 to 65 on Scale 8 have a rich imagination and are described as being creative, whereas those with low scores (T-Score < 50) tend to be conventional and concrete in their thinking. Clients in the normal range (especially if Correction [K] is relatively low) are overideational, have a rich inner life,

and tend to withdraw into fantasy when stressed. They can also become confused and unpredictably brittle and angry when stressed. They are sensitive to hostility and tend to keep others at an emotional distance. Individuals with an elevated Scale 8 have a number of things in common, including an incongruity of affect and thought content and the tendency for cognitive processing to break down under even minimal stress. Isolation from affect is a primary defense, so painful, even bizarre experiences are reported with little obvious emotional expression. These clients exhibit profoundly negative self-esteem and feel like “damaged goods.” High 8 clients feel isolated, alienated, and disconnected from others. Cold, indifferent, or hostile family relationships, general apathy, and conflicted feelings toward people they care about are common symptoms. Emotional isolation is reflected in MMPI-2 items #48 (T) and #277 (T), which describe the existential experience of loneliness and a preference to escape into fantasy and daydreaming. Scale 8 is the longest (78 items) yet perhaps the most diagnostically weak of the clinical scales. Its lack of item homogeneity is not surprising given the diversity of the eccentric, unusual, and odd behavioral and cognitive phenomena that occur in people described as schizoid, schizophrenic, or psychotic. Most individuals elevated on Scale 8, even if not overtly psychotic, acknowledge dysphoria, dissatisfaction, fearfulness, anhedonia, and other depressive symptoms. They feel hopeless, worthless, and unlovable. Not surprisingly, emotional closeness and long-term relationships are difficult. Aloof, tending to be secretive, and fearful of being rejected or humiliated, high scorers can become cognitively disorganized under stress. These individuals feel disconnected from others and from a world that appears perplexing and strange. Emotions are often experienced as alien and out of volitional control. Experiences of anger or disgust in moments when others might feel love and contentment, empty deadness in moments when others experience joy, and sexual or aggressive feelings toward inappropriate objects aggravate the cognitive slippage associated with elevations on Scale 8. Sexual urges and desires can be interrupted by fears of emotional closeness and vulnerability, eliciting approach–avoidance conflicts. One resolution of the approach–avoidance conflict is to mix or confuse sexuality and aggression. Disturbing or distracting cognitive interruptions impair the processing of everyday reality, to the detriment of basic daily activities and even minor decisions. Unable to think clearly, mistrustful, and disturbed by unusual sensory and motor experiences, many live a marginal and emotionally nomadic life. Individuals tend to develop superstitions, rituals, and eccentric behaviors that serve as a way of keeping people at a distance and perhaps give some sense of control over their environment.

(Levak, Siegel, Nichols, & Stolberg, 2011)

(T > 65)

A spike 8 profile with no other scales significantly elevated is rare and difficult to interpret. If *K* is low, so that Scale 8

is elevated mostly by the *Sc* items, it can reflect an individual who feels damaged, broken, and alienated from others. A high 8, low *K* would predict dysphoria, anhedonia, bizarre preoccupations, diffuse paranoia, and withdrawal.

They have difficulty in thinking clearly and can experience psychotic breakdowns. They are unconventional in thought and action, may be socially eccentric or deviant, and are reluctant to become emotionally involved with others. Scale 8 elevations are often associated with the need for inpatient treatment. These individuals have difficulty in communicating and their lives tend to be disorganized if not chaotic, and dysfunctional. Some exhibit periods of coherence and even productivity, but under stress they can readily decompensate. Although Scale 8 predicts schizophrenia poorly, it does predict schizophrenic-like thought processes, anhedonia, lack of social skills, and difficulties in daily functioning. These individuals tend to misunderstand others' motives and experience their inner world as outside their volitional control. Conversations with them often have a quality of being slightly "off the mark" and hard to follow. If *K* is elevated so that the *Sc* elevation is due largely to the *K* correction, the individual will exhibit many areas of compensated and efficient functioning. Even so, an underlying negative self-image and difficulty with intimacy can lead to interpersonal problems, even without psychosis. A high *K*, high 8 individual may hold eccentric beliefs and be oddly flamboyant in dress and presentation.

The data in Appendix M indicate that peak scores on scale 8 are quite rare in normal adult males and females, but are much more likely in younger subjects and in prison inmates. There is also an increase of these peaks in psychiatric samples, particularly hospitalized groups, and even in neurological patients. The relative infrequency of scale 8 peaks in the medical patients reported by Guthrie (see Tables 15 and 16 of Appendix M), even when compared with the low level for adults in general, is also striking. The terms chosen by college-level peers to describe the high 8 girls in Black's study suggest the schizoid personality pattern present in the criterion group for this scale. That is, these girls were described as apathetic, serious, seclusive, and secretive. There is little to suggest any appreciable degree of disorganization in their behavior, however, since such terms as orderly, wise, clear-thinking, and adaptable seem to convey good control and integration. These girls were also described as worldly and sophisticated, but not apparently in the sense of snobbish, since they were also described as humble, peaceful, and grateful. In addition they were seen to be courageous and to have aesthetic interests, but to be undependable. The terms that were omitted to a significant degree in the ratings of the high-point 8 girls by their peers tend to support this same picture. The omissions include mature, selfconfident, talkative, and sensitive. In their self-descriptions, the girls in the Black study who had scale 8 peaks were quite self-derogatory and critical. They labeled themselves, similarly to their peers' ratings, as serious and as having aesthetic interests, but included conceited, boastful, and selfish. They also described themselves as hostile, rebellious, and pugnacious. They said they were eccentric and

became easily bored. They also omitted the terms loyal and persevering from their self-descriptions to a significant degree.

Mello and Guthrie in their analysis of the records of college students seen in counseling found that the group who showed peak scores on scale 8 presented problems in peer relationships and group acceptance. Sexual preoccupation was frequent along with sexual confusion, nymphomaniac tendencies, and bizarre fantasies. The students relied a great deal on daydreaming. In these young subjects the role of scale 8 does not appear to have the malignant qualities it takes on in older subjects; a frank psychosis was rarely shown by these counselees. They developed a positive transference quite readily, and tended to persist in treatment more than almost any other profile type (the exception being the scale 7 peaks) even though their response to treatment was quite variable. Guthrie has also reported on a small subgroup of medical patients whose peak scores occurred on scale 8. As a group they did not show clear-cut physical symptoms, but rather presented a long history of vague complaints that had been treated by a variety of regimes. These histories strongly suggest long-standing, stabilized hypochondriacal trends. In their psychological makeup Guthrie found the peak 8 group to be rather uniformly borderline psychotics, whose only psychotic manifestations were short-lived periods of confusion and disorientation. In the main, these subjects were able to attribute their problems to "trouble with their nerves," and they showed no evidence of deeper insight into their personality problems. Consequently response to treatment was quite poor, and over the course of time their particular complaints remained vague and gradually shifted without amelioration. They seemed to be sincerely seeking help from the physician, but did not benefit from the simple reassurance that usually helped neurotics. Although these patients were not violent, they were described as disagreeable and their home life was severely disrupted by the poor control they maintained over their hostility. Drake often noted in college counselees with peak 8 profiles problems of "lack of knowledge" and of being "confused," while the peak 7 group was characterized by problems of "conflict."

(Dahlstrom, Welsh, & Dahlstrom, 1979)

Lifestyle and Family Background

Often, as children, individuals elevated on Scale 8 exhibited peculiarities, eccentricities, or a slowness to mature. Our hypothesis is that a genetic sensitivity and vulnerability to the disorganizing effects of hostility and a deleterious environment of cruel neglect or hateful hostility leads to the high 8 adaptation. Withdrawal into fantasy, keeping others at an emotional distance with bizarre behavior, and shutting down emotional and cognitive processes to escape perplexing reality makes adaptive sense. Personal eccentricities, slowness to mature, and being fearful and insecure in the presence of a hostile environment could have provoked humiliations, putdowns, and hostility from those. Developing eccentric and hostile behaviors as a self-protective way of keeping others at a distance would make

sense in such an environment. The eventual collapse of effective functioning is hypothesized to be a result of being overwhelmed both cognitively and emotionally. We do not suggest that Scale 8 is an adaptive response in such an environment but, rather, an understandable response in the face of primal threat.

(Levak, Siegel, Nichols, & Stolberg, 2011)

o Look for eccentricity, apathy, and aloofness.

Description:

Odd, eccentric, nonconformist, aloof or psychotic

Modifying Scales

- When Scale 1 is elevated, clients will complain of unusual and even bizarre somatic symptoms that may have some organic neurological basis but would generally reflect fears of being broken or damaged.
- When Scale 0 is elevated, this would overstate their interpersonal estrangement and alienation. Shyness combined with a sense of being damaged and broken would aggravate the severity of the disturbance.
- Social Alienation (Sc1) elevated suggests an interpersonally sensitivity, paranoid, fear of others, and social avoidance and isolation. Inquire about physical or sexual abuse.
- When Emotional Alienation (Sc2) is elevated, feelings of being out of touch, emotionally dead, detached, and apathetic with little positive experience are suggested.
- An elevated Lack of Ego Mastery Cognitive (Sc3) indicates cognitive disruption, feelings of being overwhelmed, an inability to think clearly, low energy, and in some cases psychotic symptoms.
- When Lack of Ego Mastery Conative (Sc4) is elevated, feelings of being defective, immobilized, and unable to “get going” even when motivated to do so are typical.
- High scorers on Lack of Ego Mastery Defective Inhibition (Sc5) feel at the mercy of impulses and experience dissociation of affect. Inappropriate laughter, surges of anger, and eccentric and inappropriate behavior and affect would characterize these clients.

- When Bizarre Sensory Experiences (Sc6) is elevated, depersonalization, derealization, dissociation, and estrangement are present. Female clients may have histories of suicide attempts and of sexual abuse. Most of the items on this subscale refer to unusual and distressing motor or sensory experiences.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Male

Low 0 Lacks knowledge or information, aggressive or belligerent.

Low 9 Introverted or self-conscious or socially insecure.

Nothing Low Indecisive, unhappy, worries a great deal, insomnia, confused.

Female

8-0 Verbal.

8-5 Lacks academic drive, distractible in study.

8-X Depressed, father conflict, mother conflict, sibling conflict, 8+ conferences, lacks skills with the opposite sex.

(Drake & Oetting, 1959)

TREATMENT

A Spike 8 low *K* codetype reflects an individual who has damaged self-esteem. Look for childhood conditioning experiences of being treated with coldness, overt hostility or cruelty. In some cases, the individual was perceived as “different” from an early age. Perhaps painfully shy or with other personal eccentricities, they were vulnerable to being treated with coldness or hostility from others. In some cases, parents were overtly rejecting. The individual may have responded adaptively by withdrawing and developing behavioral habits and clothing styles that would serve to frighten others and keep them at a distance. Escapes into fantasy and emotionally “shutting down” to avoid unbearable rejection will have been an adaptive response, although at the same time limiting the individual’s ability to process reality.

In therapy, these individuals may avoid eye contact and be difficult to engage. They have difficulty trusting, and anticipate the therapist rejecting them or feeling hostility toward them. Watch how the conversation may become interrupted during moments of vulnerability, as they say something distancing or odd, perhaps as an unconscious preemptive attempt to maintain distance and control. Insight therapy should be avoided as structured reparenting therapies are more appropriate. These individuals need structure because they have difficulty “reading” others’ emotions. Self-esteem building and practical life-skill management are usually most appropriate. If the therapist can

occasionally share minor vulnerabilities, it can help the patient feel less vulnerable to judgment for being “different.”

Therapy and Therapeutic Pitfalls

Clients with a high Scale 8 are alienated and often mistrustful. Although psychotropic medication is often useful, without the development of trust it is hard to develop rapport. Even nonpsychotic clients are guarded and exhibit the hostility, coldness, and indifference toward the therapist that they expect from others. An overly familiar and friendly therapeutic attitude may be met with suspicion and discomfort. Interpersonal warmth with structure and professional objectivity can help to establish trust. In brief therapy, teaching basic social skills (Corrigan, 1991), thought stopping, and relaxation techniques can be useful. It would be hard for these clients to benefit from relaxation exercise, however, until they have developed some control, usually through medication, over their disruptive internal environment. Helping clients recognize what types of stress precipitate cognitive disorganization could be useful. During therapy sessions, should clients reveal cognitive slippage or psychotic-like symptoms, therapist awareness of the valence shift should lead to asking the client the cause of the fear, stress, or anger. Such moments provide an opportunity to teach clients to recognize when they become disorganized and to rehearse self-calming exercises. For example, the therapist might observe, “Right now, I’m not able to follow you; did something frighten you, upset you, or make you angry? Is it anything I said or did that made you feel that way?” Giving the clients accurate feedback about what is happening in the here and now can help them to recognize when they experience stress and can teach more socially appropriate responses. Should higher-functioning clients express sexual concerns, a useful resource is *Treating Sexual Shame: A New Map for Overcoming Dysfunction, Abuse, and Addiction* (Hastings, 1998).

Long-term supportive, structured, but nurturing therapy can help repair damaged self-esteem (McKay & Fanning, 2000) and teach the management of cognitive disruption and emotional panic. Discussing how the client is feeling in the moment, and discussing the therapist–client interactions (as long as the therapist is authentic and not hostile) is a way of repairing damaged identity and teaching social skills. Social skill building and helping the client with social support systems and collateral contact with family and friends is also often helpful. (Levak, Siegel, Nichols, & Stolberg, 2011)

Treatment and Self-Help Suggestions

1. Often, medication can help to take away the disquieting thoughts, the dark moods, and the feelings of unreality. It can also aid you in thinking more clearly and not feeling so empty and alone. It is important that you and your therapist talk openly about any uncertainty or concerns you have about taking

medication.¹

2. If you find yourself daydreaming or having cruel, angry, or hostile fantasies, learn how to switch off your thoughts and focus on more positive things. Work with your therapist to identify some of the most distressing and negative intrusive thoughts that you have. “Thought stopping” is an effective technique you can practice to help you prevent the types of unwanted thoughts that can make you feel anxious. Several forms of thought stopping are effective. One quick technique involves picturing or saying out loud, “Stop,” whenever you experience these types of unwanted thoughts. You then replace the thought with a pleasant image or affirmation that is more positive (e.g., “I have felt this way before, and I know I can handle this”).
3. Resilience building: When you feel dark moods sweep over you, don’t give into them. Because you anticipate the worst and have difficulty focusing on the positive, keeping a daily “gratitude journal” can help instill a sense of hope and can help to replace some of your negative thinking with more primitive thoughts and feelings. Instructions for keeping a gratitude journal as well as other ways to create a more satisfying life can be found at www.authentic happiness.sas.upenn.edu/images/TimeMagazine/Index.htm.
4. Don’t assume that people are going to hate you and that you are unlovable. Your tendency is to think that all reactions by others toward you are negative. You may feel so self-conscious that you believe people are looking at you critically. Remember that you are knocked off balance right now and that you are probably misinterpreting others’ motives.
5. See if you can become aware of negative, self-critical thoughts such as telling yourself that you are unlovable or somehow defective. This type of harsh self-judgment can cause a great deal of pain. Work with your therapist on ways to increase your self-esteem.² There are a number of good techniques including personal wellness, setting goals, self-expression, looking at “core beliefs,” and monitoring your “self-talk.”
6. Resilience building: Work with your therapist to identify your positive traits and “Signature Strengths.” Write them in a list, and read them every day. For more help identifying your Signature Strengths see www.authentic happiness.sas.upenn.edu.

7. If people are nice to you, don't assume it's a trick. Work with your therapist to identify people or agencies that you have difficulty trusting. See if the two of you can discover any fear-based types of "distorted thinking," and then work to challenge those old beliefs that are not helpful to you right now. One type of distorted thinking is called "overgeneralization" (e.g., assuming that because someone was cruel to you in the past all people will be cruel). A more helpful way of thinking would be that just because one person was cruel does not mean that no one will ever be kind again.³
8. Role play with your therapist to develop your social skills, to foster your relationships, and to help you create new ones.⁴

¹ Compliance therapy combines principles of motivational interviewing, inductive questioning, reflective listening, and reinforcing adaptive behaviors and attitudes to explore client ambivalence and target medication adherence (Kemp, David, & Hayward, 1996).

² Although some studies find that positive affirmations are helpful (Philpot & Bamburg, 1996), others have found it to be neutral to harmful for those with very low self-esteem (Wood, Perunovic, & Lee, 2009). For situational low self-esteem, cognitive techniques and affirmations can help change maladaptive patterns, but for characterological low self-esteem the emphasis should be on negative core beliefs, maladaptive schemas, and developing self-compassion (McKay & Fanning, 2000).

³ *Mind Over Mood* (Greenberger & Padesky, 1995). This workbook contains exercises such as thought stopping and keeping a thought record to overcome negative and destructive thinking.

⁴ A meta-analysis was conducted on 73 studies of social skills training in four adult psychiatric populations: developmentally disabled, psychotic, nonpsychotic, and legal offenders. Patients participating in social skills training programs broadened their repertoire of skills, continued to demonstrate these skills several months after treatment, and showed diminished psychiatric symptoms related to social dysfunctions (Corrigan, 1991).

(Levak, Siegel, Nichols, & Stolberg, 2011)

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that the world currently may be somewhat frightening to you. You may be spending a lot of time thinking and daydreaming, but some of your thoughts may be frightening and you may feel that you do not have control over them. You may feel unsafe in a world that at times you find difficult to understand. People with your profile sometimes grew up in environments where a caretaker treated them coldly or cruelly. From an early age you may have learned to protect yourself by withdrawing and keeping people at a distance. Perhaps you dressed or acted in ways that frightened others, so that they would stay away from you and not invade your privacy. Currently,

it may be hard for you to think clearly and make good decisions. You tend to be your own worst critic and you may be feeling that you are somehow damaged or broken, and therefore unlovable. It is hard for you to open up and allow people to get close because you are afraid they will hurt you. At times, it may feel as if your mind is playing tricks on you, so that it is hard to know what is real and what is imaginary. You may feel “invaded” by thoughts and feelings that are frightening, and even though you may want to switch off some of your thoughts, you may find it hard to do so. It may be hard to concentrate and remember things, and often your experiences may feel almost dreamlike, as if you’re somehow outside your body. You may find that little in life gives you pleasure and you feel a constant sense of emptiness and dread. Your therapist may want to give you some medication that could help you organize your thoughts better and think more clearly. Work with your therapist to understand how closeness with others can be frightening to you since you grew up in an environment where you felt vulnerable to others’ anger and hostility. Learn how to be more assertive so that you can tell people what you’re feeling before you are angry. Learn how you keep others at a distance by some of the things you say and do, and work at finding ways to express what you are feeling in ways that others can understand.

Feedback Statements—Elevated Profiles (T-Score > 65)

Strengths

Your profile suggests that when you are feeling better you can make use of some of your psychological strengths. You are an imaginative, creative person who thinks differently from others.

Confused, Depersonalization, Derealization

Currently, you seem to be knocked off balance and confused. The world may be a somewhat frightening place right now because it’s hard for you to read people and to know how they’re feeling toward you. You may feel disconnected from others, as if you are looking at the world from a distance. Perhaps you feel as if you’re outside of your body looking in on a world to which you don’t feel you belong. This feeling of apartness from yourself is called depersonalization. Feeling as if things are not quite real, as if you’re watching them in a movie, is called derealization.

Isolated From Affect or Dark Moods

Even when things are going well or in a tender or sweet moment, you may find yourself feeling strangely cold or even angry or disgusted. Moments that others find happy or tender might leave you untouched. You may experience dark moods where you suddenly feel angry, empty, and irritable, and you might not know where the mood comes from. In fact, these dark moods may sweep over you even when things are going relatively well.

Difficulty Trusting or Paranoid

You can become overwhelmed by strange emotions unexpectedly, so it's hard for you to enjoy emotionally connecting with others. It's hard to trust people because you feel as if others are wearing a mask. You're afraid that if you let down your guard and if you show people your vulnerability they will take advantage of you or be cruel. It's hard to be around people because you feel uncomfortable. Your profile suggests that you are sensitive to others' anger and dislike. At times, you may feel paranoid, afraid that people are out to get you and that you can't trust anyone.

Difficulty Concentrating

It's hard for you to focus and plan effectively because it's difficult to control your thoughts and organize them in a meaningful way. When you're attempting to concentrate, you may experience interruptions to your thinking as if you don't have control over your mind. Sometimes the thoughts that come into your mind may be disturbing, and sometimes they can frighten you.

Preoccupied With Fantasies/Anhedonia

You have a tendency to daydream and spend time inside your mind fantasizing; sometimes the daydreams may be disturbing. Spending time in your own thoughts may make it hard for you to get things done. Life must feel somewhat gray, empty, and at times meaningless. It's hard to get motivated and to have goals and ambitions because nothing seems worthwhile or rewarding.

Hallucinations

You may get so tense that you may be unable to decide what is real and what is not. Sometimes you may hear your thoughts spoken out loud, as voices. In some rare cases, people with your profile actually have hallucinations where they see things and hear things that others don't see. Some of these frightening hallucinations and paranoid thoughts may get so intense that you withdraw and hide.

Lifestyle and Background Feedback

People with your profile may have grown up in homes with parents who were angry or even hostile and cruel. Perhaps as a child you were sensitive and easily knocked off balance by rejection and criticism. You may have had some habits such as stuttering or childhood bedwetting, which left you vulnerable to being teased and humiliated. Because of your sensitivity, you may have experienced your childhood as particularly painful. It's also possible that

others ignored you, and treated you with contempt or cold hostility. This was very painful, so when you needed support it was difficult to know where to turn because you were afraid that the people around you would be cruel and rejecting. You may have protected yourself by retreating into daydreaming and fantasy. You may have fantasized about how to pay others back and to treat them cruelly to punish them for what they were doing to you. It could be that you are going through a similar period right now, feeling hated, disliked, or rejected.

Normal-Range Feedback (T-Score 60 to 65)

Your profile is in the normal range and reveals that you may be a creative person readily able to escape into a rich fantasy world. Others may see you as eccentric and somewhat difficult to get to know. You are sensitive and may become knocked off balance if you perceive anger or hostility from others.

There are other times, however, when disturbing thoughts can interrupt your concentration and surges of emotion can make you feel out of control. You may periodically experience bad moods when you feel empty, isolated, and disconnected from others. At these times you may find that you prefer to be alone, and intrusions may make you tense. You don't like to be open or vulnerable with others until you are certain that they won't be mean to you or treat you badly. When you sense that someone is angry with you, your thinking becomes muddled and you may respond with anger or withdrawal. People with this profile grew up in environments where a parent or caretaking figure sometimes treated them with hostility, coldness, or even cruelty. No wonder you are particularly sensitive to antagonism from others and that you become knocked off balance if you perceive it. You learned to be cautious, keeping an emotional distance from people until you can really trust them.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Relations with Other Scales

81/18 Codes

See 18/81 Codes.

These cases are included in the 8123 pattern reported by Gilberstadt and Duker.

8123 Code

1. Gilberstadt and Duker (1965) found the 8-1-2-347-4-6-0) pattern in a VA hospital male population. Scales 7, 4, 6, and 0 are elevated above 70, but they are not necessarily the next highest scales after scales 8, 1, 2, and 3. A man with this profile typically was inadequate in all areas of his life. He usually had confused thinking and flat affect. The Gilberstadt and Duker book should be consulted for further information concerning this profile.

82/28 Codes

See 28/82 Codes.

Data on this configuration appear in the 28-82, 482-824 subgroups in the Marks and Seeman Atlas and in the 824 prototype reported by Gilberstadt and Duker.

8-2 See also the 2-8 combination, pp. 111-113, especially point 6.

1. Marks et al. (1974) found this 24/8-2 pattern in a university hospital and outpatient clinic. People with this pattern were usually anxious, depressed, and tearful. They tended to keep people at a distance and were afraid of emotional involvement. They tended to fear loss of control and reported periods of dizziness or forgetfulness. The Marks, Seeman, and Haller book should be consulted for further information concerning this profile.

824 Code

- Marks et al. (1974) found this 4-8-2/8-4-2/8-2-4 pattern in a university hospital and outpatient clinic. A person with this profile tended to be distrustful of others, keeping them at a distance. He/she usually was described as depressed, tense, irritable, and hostile. The Marks, Seeman, and Haller book should be consulted for further information concerning this profile.
- Gilberstadt and Duker (1965) also found an 13-2-447) pattern in a VA hospital male population. Scale 7 is elevated, but it is not necessarily the next highest scale after 8, 2, and 4. They found that a person with this profile was immature and had confused and hostile thinking. He tended to be irritable, tense, and restless. The Gilberstadt and Duker book should be consulted for further information concerning this pattern. (Marks, Seeman, & Haller, 1974)

83/38 Codes

See 38/83 Codes.

Diagnosis

Psychosis 48% Schizophrenic/manic depressive
 Psychoneurosis 43%+ Dissociative/mixed
 Personality disorder 10% Schizoid
 Brain syndrome 0%

Rules
8, 3, and 1 above 70 Ts
3 minus 1 less than 10 T-scores
3 minus 2 more than 5 T-scores
8 greater than 3 (or 3 minus 8 less than 5 T-scores)
8 minus 7 more than 5 T-scores
8 minus 9 more than 10 T-scores
9 greater than 0
0 below 70 Ts

Most Descriptive

- 103. Reports difficulty in thinking; can't concentrate (8.8) +
- 45. Thinks and associates in unusual ways; has unconventional thought processes (8.6) ++
- 104. Delusional thinking is present (8.4) +
- 57. Seems unable to express own emotions in any modulated adaptive way (8.2) +
- 1. Is vulnerable to real or fancied threat; generally fearful; is a worrier (8.0) +
- 20. Complains of difficulty in going to sleep (8.0) +
- 40. Genotype has schizoid features (7.8) +
- 58. Tends to be ruminative and overideational (7.8) +
- 79. Is resentful (7.8) +
- 93. Exhibits depression (manifest sad mood) (7.8)
- 65. Has an exaggerated need for affection (7.6) +
- 85. Has inner conflict about emotional dependency (7.6)
- 5. Possesses a basic insecurity and need for attention (7.4) +
- 26. Reacts to frustration intropunitively (i.e., punishes self) (7.4) +
- 90. Is apathetic (7.4) + +
- 55. Has feelings of hopelessness (7.2) +

- 99. Is stereotyped and unoriginal in approach to problems (7.2) + +
- 12. Tends not to become involved in things; is passively resistant (7.0) +
- 16. Is overanxious about minor matters and reacts to them as if they were emergencies (7.0) +
- 28. Is evasive (7.0) +
- 74. Utilizes regression as a defense mechanism (7.0) + +

Least Descriptive

- 37. Defenses are fairly adequate in relieving psychological distress (1.0) —
- 42. Is "normal," healthy, symptom free (1.0) —
- 39. Genotype has psychopathic features (1.2) —
- 11. Is cheerful (1.4)
- 59. Is socially extroverted (outgoing) (1.4) —
- 63. Has a resilient ego-defense system; has a safe margin of integration (1.4)
- 49. Appears to be poised, self-assured, socially at ease (1.8) —
- 89. Is provocative (1.8) —
- 9. Presents self as being physically, organically sick (2.2) —
- 36. Has a rapid personal tempo; thinks, talks, moves at a fast rate (2.2) —
- 51. Exhibits good heterosexual adjustment (2.2)
- 61. Tends to be flippant both in word and gesture (2.2) —
- 41. Has good verbal-cognitive insight into own personality structure and dynamics (2.6)
- 25. Presents a favorable prognosis (2.8)
- 67. Is able to sense other person's feelings; is an intuitive, empathic person (2.8)
- 69. Gets along well in the world as it is; is socially appropriate in own behavior (2.8)
- 84. Is critical; not easily impressed; skeptical (3.0) —

Personality Description

Quite prominent in the psychological status of the 8-3 patient is a notable disorder in the thought process as reflected in the flow of speech. The clinicians who observed this group characterized their thinking as unconventional, unusual, schizoid, and autistic; often what is said seems irrelevant or incoherent. Thinking and concentration difficulties are also subjectively reported. Twenty-five per cent of these patients further report that

lapses of memory pose a problem for them. Delusions and hallucinations are frequent, but by no means always present.

Depression is a dominant feature in the emotional tone of these patients. Consistent with this, the typical reaction to frustration is intropunitive (self-punishing). Feelings of hopelessness are openly expressed. Adjectives used to describe the 8-3 are resentful, anxious, tense, and nervous. Also seen as ruminative and obsessional, these patients are easily threatened, generally fearful, and constantly worrying. Phobias are present in about 30% of the cases. This makes for strong overreaction to minor irritants which are often interpreted as major threats. Thus, there is a lack of emotional balance—a characteristic lack of adaptability. Patients who obtain this profile tend to be indecisive and immature. Sleep difficulties are reported frequently.

These patients possess a basic insecurity, inner conflict about sexuality, excessive needs for attention, and exaggerated needs for affection. There is a stereotyped and unoriginal quality in their approach to problems. They are viewed as evasive, uninvolved, apathetic, and passively resistant. The degree of clinically rated regression is well beyond the base rate for our psychiatric population.

Although 8-3's are not perceived by clinicians as "somatizers," they do report a fair amount of physical distress; 60% claim musculoskeletal difficulties and 25% say they experience genitourinary problems. One-third have blurred vision. Other complaints include dizziness, chest pain, genital pain, headaches, numbness, and paresthesia.

Typically, patients with this profile are not the oldest child—often they are the youngest. Childhood health is generally good, as is academic achievement; half of these people do above average work in school and 42% are educated beyond the high school level. Although an unusually small percentage of these patients come from disrupted homes, 30% report one or both parents alcoholic with 25% of all fathers being alcoholic. Fifteen per cent of the parents also had known mental illness. Fathers tended to be affectionate yet dominating, while mothers, if not affectionate, were not neglecting. The 8-3 patient tends not to be "psychopathic." They are neither poised in social situations nor are they provocative. Their tempo is not particularly rapid and their speech and manner are neither flippant nor flighty. Neither are they likely to be viewed as suspicious, skeptical, or critical. In many cases, there is no response to treatment and when there is improvement, it is only minimal. The prognosis for these patients is fair to poor.

8-3 See also the 3-8 combination, p. 130.

1. This pattern combines a moderate amount of distress, plus some somatic complaints, especially headaches and insomnia (Lachar, 1974).

2. Marks et al. (1974) found the 8-3/34 pattern in a university and outpatient clinic. The pattern usually was for a woman who was having difficulties thinking and concentrating. She usually was seen by others as apathetic, immature, and dependent. The Marks, Seeman, and Haller book should be consulted for further information concerning this profile.

84/48 Codes

See 48/84 Codes.

8-4 See also the 4-8 combination, p. 154.

- These people tend to be high school dropouts (Hathaway et al., 1969).

85/58 Codes

See 58/85 Codes.

- The inhibition suggested by the 5 scale and the fragmentation suggested by the 8 scale may lead to an isolated, destructive act by an individual who is typically over-controlled (Trimboli & Kilgore, 1983).

86/68 Codes

See 68/86 Codes.

Diagnosis

Psychosis 68% Schizophrenic/paranoid

Personality disorder 18% Paranoid

Brain syndrome 14% Chronic

Psychoneurosis 0%

Rules

8, 6, 4, and 2 above 70 Ts

1 and 3 less than 2, 6, 7, and 8

2 minus 1 more than 10 T-scores

6 minus 5 more than 25 T-scores

6 greater than 7

8 minus 7 more than 10 T-scores

8 minus 9 more than 10 T-scores

F greater than L and K, L and K below 60 Ts

Most Descriptive

45. Thinks and associates in unusual ways; has unconventional thought processes (8.8) + +

104. Delusional thinking is present (8.8) +

58. Tends to be ruminative and overideational (8.6) +

96. Genotype has paranoid features (8.6) +

24. Spends a good deal of time in personal fantasy and daydreams (8.2) + +

57. Seems unable to express own emotions in any modulated adaptive way (8.2) +

17. Utilizes projection as a defense mechanism (8.0) +

100. Obsessive thinking is present (8.0) +

10. Fears or phobias present (7.8) +

40. Genotype has schizoid features (7.8) +

78. Is irritable (7.8) +

79. Is resentful (7.8) +

86. Is shy, anxious, and inhibited (7.8) +

19. Is unpredictable and changeable in behavior and attitudes (7.6) +

68. Keeps people at a distance; avoids close interpersonal relationships (7.6)^

85. Has inner conflicts about sexuality (7.6)

97. Is sensitive to anything that can be construed as a demand (7.6) +

44. Is distrustful of people in general; questions their motivations (7.2)

103. Reports difficulty in thinking; can't concentrate (7.2)

62. Exhibits evidence of narcissism (latent or manifest) (7.0) +

106. Has grandiose ideas (extreme is delusions of grandeur) (7.0) + +

Least Descriptive

30. Has "diagnostic" insight; awareness of the descriptive features of own behavior (1.2)

42. Is "normal," healthy, symptom free (1.2)

67. Is able to sense other person's feelings; is an intuitive, empathic person (1.4)

15. Tends not to become involved in things; is passively resistant (1.6)

- 39. Genotype has psychopathic features (1.6)
- 107. Would be organized and adaptive when under stress or trauma (1.6)
- 11. Is cheerful (1.8)
- 41. Has good verbal-cognitive insight into own personality structure and dynamics (1.8) —
- 51. Exhibits good heterosexual adjustment (1.8) —
- 59. Is socially extroverted (outgoing) (1.8)
- 108. Has the capacity for forming close interpersonal relationships (1.8) —
- 25. Presents a favorable prognosis (2.0) —
- 27. Has shown ability to talk about conflicts in most areas (2.0)
- 37. Defenses are fairly adequate in relieving psychological distress (2.0)
- 50. Has a need to affiliate with others (2.0) —
- 63. Has a resilient ego-defense system; has a safe margin of integration (2.0)
- 95. Accepts others as they are; is not judgmental (2.0) —
- 49. Appears to be poised, self-assured, socially at ease (2.6)
- 4. Has a need to think of self as an unusually self-sufficient person (2.8) —
- 102. Genotype has hysteroid features (2.8)
- 53. Is open and frank in discussing problems (3.0) —
- 61. Tends to be flippant both in word and gesture (3.0)

Personality Description

The pattern of the validity scales L, F, and K indicates honesty in responding to the test questions and a tendency toward self-derogation; this lack of self-confidence and low self-esteem is also commented on by Gilberstadt and Duker (1965). The low K corresponds to decompensation of the patient's defenses, accompanied by florid psychological symptomatology. The extreme elevation on scale F reflects confusion and considerable ego disorganization.

These patients subjectively report difficulty in thinking and in concentration. Clinicians unanimously concur that these patients think in a disordered, unusual, unconventional, and autistic way. Thinking is also characterized as obsessional and suicidal ruminations are frequent. Delusions, grandiose ideas, excessive fears, and phobias are all common. Clinicians are also impressed that the 8-6 patient spends a great deal of time in personal fantasy and in daydreaming. It is not surprising that the majority of these patients are diagnosed as paranoid schizophrenics, their predominant defense mechanism being projection. The general orientation of these patients toward others is one of suspicion and distrust; the motivations of others are regarded as questionable and highly suspect. Avoidance of close

interpersonal relationships and hence, emotional distance from others, is a typical pattern for patients who obtain this profile. The 8-6 patient is described as schizoid, inhibited, shy, withdrawn as well as irritable, resentful, anxious, and sensitive to anything that can be construed as a demand. These are descriptive adjectives also applied to the 8-6 patient studied by Gilberstadt and Duker (1965). The erratic character of these patients' behavior has led clinicians to view them as unpredictable. They tend to be moody, rigid, negativistic, manipulative, emotionally immature, and emotionally inappropriate; they exercise poor judgment and are generally uncooperative and apathetic. Feelings expressed by the 8-6 patient include inferiority, guilt, and unreality. It is no wonder that they do not arouse liking and acceptance in others.

Patients with this profile were quite often either an only child, or the youngest in the family. Both parents were characterized as rejecting or indifferent at best. School achievement was frequently below average which is consistent with our findings that these patients obtained the second lowest IQ scores of any group studied on both the Shipley and WAIS (mean full scale IQ's of 101 and 102, respectively).

The onset of their disorder is typically quite short. Their prognosis is fair to poor, regardless of the fact that 85% demonstrate at least some positive response to treatment with about 50% showing decided improvement.

(Marks, Seeman, & Haller, 1974)

8-6 See also the 6-8 combination, pp. 184-185.

1. A person with this pattern is usually in a panic and has diffused thinking. The person tends to break down when supports are gone (Caldwell, 1972).
2. Often these people do not marry, but if they do marry, they tend to show poor judgment in mate selection (Caldwell, 1972).
3. Women often have a little girl quality about them and look younger than they really are (Caldwell, 1972).
4. In a psychiatric hospital, this may be the profile of an assaultive person (Caldwell, 1972).
5. Marks et al. (1974) found this 8-6/6-8 pattern in a university hospital and outpatient clinic. They found this pattern primarily for females who were having unconventional, delusional thoughts. These women also were suspicious. The Marks, Seeman, and Haller book should be consulted for further information concerning this profile.

6. Gilberstadt and Duker (1965) found the 8-647-2) pattern in a VA hosnital male population. Scales 7 and 2 are elevated but arc not necessarily the next highest scales after scales after 8 and 6. A man with this pattern tended to have thinking disturbances, such as confusion and poor concentration. He tended to be shy and withdrawn. The Gilberstadt and Duker book should be consulted for further information concerning this profile.
7. Megargee and Bohn (1979) found a group of incarcerated criminals with the 64/8-6 profile (Group Charlie). (Others in the groups had an 8-4 profile.) These men tended to be antisocial, bitter, hostile, aggressive, and sensitive to perceived insults. They had extensive criminal records and ranked high in substance abuse. However, because they were socially isolated they did not have a number of disciplinary writeups.
8. Anderson et al. (1979) have found this pattern as one of three profiles in a group of sex offenders. (The other two profiles were 4-9 and 2-4.) These people often had sex offenses that blatantly degraded the victim. They showed long term socially maladaptive behavior. They tended to act out in self-defeating ways and showed chronic bad judgment. The F scale was also elevated for this profile
9. In one study (Kurlychek & Jordan, 1980) of criminals judged responsible or not responsible for their crimes due to mental illness, those judged not responsible had the 84 code as the modal code type (30% of the cases). However, this study had a small number of subjects.

8649F Code

In a Mexican prison, thirty women were found with this profile pattern. All were convicted of homicide, nine of them were self-made widows (Palau, 1972).

867F Code

Anderson and Holcomb (1983) found two of their five MMPI code types of murderers to have this configuration.

- a. Murderers with the most elevated 8-6-7-F code type came from the most disturbed background. They were confused, immature, and perhaps mentally deficient. They tended to have killed strangers.
- b. Murderers with the lower 8-6-7-F profile were more likely (88%) to be considered to have no mental disorder despite their profile elevation. However, 47% had had previous psychiatric evaluations or

treatment. They were most likely on drugs or drinking at the time of their crimes. They also tended to kill strangers. They fit Megargee and Bohn's (1979) Group Charlie.

87/78 Codes

See 78/87 Codes.

8-7 See the 7-8 combination, p. 195.

1. Panic plus withdrawal may be present for a person with the 8-7 pattern (Caldwell, 1972).
2. The 8-7 pattern may indicate long-standing feelings of inadequacy, inferiority, and insecurity (Halbower, 1955). Very frequently the person feels himself/herself to be the inferior member of the family (Caldwell, 1972).
3. These people tend to be passive-dependent. If they are the Dy scale will be above 50 T-score points.
4. A clear cut psychosis with great turmoil is likely (Lachar, 1974).
5. Prognosis for therapy is poor, because these people do not form stable, mature, or warm relationships easily. They usually do not integrate what they learn or profit from their own experiences (Halbower, 1955).
6. This profile indicates more serious problems than a 7-8 profile does. There may have been mental hospitalization and/or therapy.
7. With a high F scale and an 8-7 pattern, the person may feel unreal (Caldwell, 1972).
8. With a high 0 scale and an 8-7 pattern, social withdrawal may exist (Caldwell, 1972).
9. With a low 0 scale and an 8-7 pattern, inappropriate behavior may exist (Caldwell, 1972).

10. In one study (Kurlychek & Jordan, 1980) of criminals judged responsible or non-responsible for their crimes due to mental illness, those judged responsible for their crimes had the 8-7 code as the modal code type (20% of the cases). However this study had a small number of subjects.

872 Code

I. Marks et al. (1974) found this 2-7-818-7-2 pattern in a university hospital and outpatient clinic. A person with this pattern typically was described as tense, anxious, and depressed with confused thinking and much self-doubt. The Marks, Seeman, and Haller book should be consulted for further information concerning this pattern.

876 Code

1. This pattern was found in a group of male alcoholics. Also found were the 2-1-3, 2-4-7, and 4-9 combinations (Conley, 1981).

89/98 Codes

Code-Type 8-9/9-8

Descriptors

Complaints

Hyperactivity, flight of ideas, emotional inappropriateness, impulsivity, agitation, restlessness, panic, difficulties with concentration, possibly hostile

Thoughts

Grandiose, possible delusions or hallucinations, paranoid, uses projection, unusual or possibly autistic association process, indecisive, disoriented, disorganized thought processes, obsessive, possible suicidal thoughts

Emotions

Excessive fears, phobias, low self-confidence, low self-esteem, self-derogatory, confused, possible paranoia, distrustful, inhibited, irritable, anxious, resentful, moody, negativistic, emotionally inappropriate

Traits/Behaviors

Grandiosity mixed with low self-esteem, agitated, hypomanic, disorganized, confused, manic or schizoid thinking, religious or sexual preoccupations, unpredictably irritable, suspicious, paranoid, demanding, resists demands

Strengths

Active, energetic, creative, rich fantasy life, novel ways of problem solving, high standards, ambitious

(Levak, Siegel, Nichols, & Stolberg, 2011)

Typically, the validity pattern with this codetype is associated with low *L* and low *K* scores with an elevated *F* scale, suggesting a candid, honest, somewhat panicked, “pleading for help” approach to the test items. Not surprisingly, this codetype suggests serious psychopathology, even when the scales are not highly elevated above a *T*-score of 65. The 89/98 individual feels inferior, inadequate, and has low self-esteem, but at the same time is disorganized, hypomanic, grandiose, and confused. They evidence hyperactivity, excitability, and disorientation. A combination of hypomania or mania, together with the Scale 8 characteristics of cognitive disorganization and damaged self-esteem, suggests an individual who is defending against feelings of inadequacy. These individuals are highly over-ideational and spend a great deal of time in fantasy, daydreams, and rumination. They are tense and agitated, and insomnia is likely. Pressured speech, behavioral restlessness, emotional lability, and flight of ideas are likely. They are highly distractible, switching from topic to topic in response to anxiety-laden material. They have difficulties with attention and concentration. A psychosis may be present and can manifest as bizarre religious and sexual preoccupations. Physical symptoms of stress, such as gastrointestinal and neurological symptoms, may also be present, reflecting the high level of internal tension. Moods may switch from being grandiose to hostile and demanding. The 98/89 individual often exhibits a loud voice, and can also show suspiciousness and paranoid episodes. Some actually may withdraw into autistic-like episodes, although their internal thought processes can be hypomanic. Typically, the precipitating circumstance is a perceived sexual rejection or humiliating setback. Often these individuals exhibit a history of aspirations of high achievement, but mediocre actual attainment. Perceived failure is often the precipitating cause of a hypomanic, disorganized 89/98 response. At increased elevations, there is increased likelihood of delusions and hallucinations, particularly of a religious nature. In the 1960s, this codetype was reported as common among people who experimented with LSD and had experienced a “bad trip.” The term “schizo-manic episode” describes this codetype well, suggesting manic and psychotic symptoms. These individuals are extremely perfectionistic, so failure is experienced as disastrous and tends to confirm their negative self-concept. They are extremely self-critical and easily knocked off balance by rejection. The profile is often associated with an identity crisis precipitated by a failure or a rejection.

Therapist's Notes

In the normal range, the 8-9 code type indicates individuals with few serious problems, although some may be experiencing a mild identity crisis or situational adjustment. In this normal range these individuals show ambition, drive, and sensitivity to failure. They are creative problem solvers who “think outside the box.”

Elevations reflect the operation of hypomanic defenses against a backdrop of cognitive and emotional disorganization. Hypomania and grandiosity interact with schizoid disorganization so that these individuals experience paranoid, persecutory, and expansive thinking such as conspiracy theories, religious preoccupations, and other eccentric belief systems.

Typically, the validity scales associated with this profile reveal a high Infrequency (F), low Lie (L), and low Correction (K), reflecting a panicked, disorganized disturbance. Although often grandiose, they manifest low self-esteem and feelings of inferiority. Many 8-9 individuals are delusional and display emotional lability and inappropriateness. They spend a great deal of time in fantasy and report difficulties in concentration and thinking. Their thought processes are odd and eccentric and they have bizarre associations. These clients are often erratic and unpredictable, and they are unable to modulate their behavior in an adaptive way. They have periods of hyperactivity and panic and then periods where they are irritable, demanding, and hostile. They may be talkative, although circumstantial and confused. In some cases this profile has been associated with an identity crisis, precipitated by a rejection or a perceived failure.

Typically, the onset of this disorder is quite rapid, and the duration tends to be somewhat shorter than for other disturbances. Previous episodes are reported in a large number of 8-9 cases. When clients obtain this code type in late adolescence or early adulthood, it may be induced by chemical substances. Among adults, this profile is often associated with low self-esteem and panic about rejection. Typically, 8-9 code types have very high self-expectations so that perceived failure is experienced as disastrous. Perhaps compensating for their low self-worth, they have grandiose self-expectations and any failures are experienced as a panic about being damaged, defective, and unlovable. They are very self-critical and experience rejection as catastrophic. They see it as a result of their failures to live up to others' expectations. They may use substance as a way to medicate both their hypomania and their cognitive disorganization.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Diagnosis

Psychosis 70%+	Schizophrenic/mixed
Psychoneurosis 17%	Depressive

Brain syndrome 9% Acute

Personality disorder 0%

Rules

8 and 9 above 70 Ts

5 above 40 Ts

8 minus 7 more than 5 T-scores

8 greater than 9 (or 9 minus 8 less than 5 T-scores)

0 below 70 Ts

F greater than L and K

Personality Description

The typical validity scale pattern of the 8-9 type (low L and K with elevated F) indicates a candid, honest approach to the test questions in the context of feelings of inferiority and inadequacy, low self-esteem, and a disorganization of thought processes. Consequently, it is not surprising that this code represents primarily an inpatient rather than outpatient group; 85% of the patients with this profile were hospitalized on a psychiatric service.

Mean clinical ratings indicate extraordinarily high agreement that the 8-9 patient is likely to be grossly delusional (hence paranoid) and to reflect the emotional inappropriateness that is a cardinal symptom of a schizophrenic disorder. In fact, 70% are diagnosed psychotic. Grandiose ideas and hallucinations are frequently noted and projection is seen as a major mechanism of defense—second only to regression! Clinicians judge these patients to spend a good deal of time in personal fantasy and in daydreaming. Not only are there reports of difficulty in concentration and thinking, but the structure of the thoughts—as revealed in speech—indicate an unusual, odd, autistic association process. Thus, the impression is one of considerable regression insofar as the thinking and behavior of these patients is concerned. Their behavior is endowed with a generally erratic character so that they are often seen as unpredictable. They appear unable to modulate or tone down their behavior in any adaptive way. Attempts at problem-solving fall into ineffectual, stereotyped, and unoriginal approaches. Patients with this profile are often agitated, uncooperative, irritable, indecisive, hostile, restless, impulsive, and negativistic. They express feelings of unreality, perplexity, and are often disoriented for place and time. Fifteen per cent report alcoholism with 10% reporting drug abuse.

Insofar as their relation to others is concerned, they are distrustful, suspicious, and questioning of their motivations. Being afraid of emotional involvement, they manage to avoid close interpersonal contacts and to keep people at a distance. Inner conflicts about sexuality are strong and stressful; only 55% of these patients are married.

Most of our 8-9 patients have elevations on scale 7 (or scale 7 is the highest of the profile) which accords with the clinical judgment that they are ruminative, overideational, and obsessional. Many have a schizoid component to their personality; they feel isolated and are socially withdrawn. Nearly half report that dating is a rare or nonoccurrent event. Most often, the 8-9 patient was a middle-child. School achievement followed a normal curve and 24% have a college education despite the fact that this is one of the least test intelligent groups studied; the mean WAIS IQ is 92, while the Shipley is 104. The onset of this disorder is typically quite rapid, the duration is somewhat shorter than for other codes, and previous episodes of some sort were reported in 60% of the cases.

(Marks, Seeman, & Haller, 1974)

Lifestyle and Family Background

Our hypothesis is that, in addition to any genetic predisposition, the 8-9 code type is a response to feeling disfavored and rejected, sometimes relative to perceived superior siblings. Marks and Seeman (1963) reported that, most often, the 8-9 code types were middle children and had poor school performance, and some were seen as bullying, aggressive, and bossy, possibly reflecting their low self-esteem. Elevations on Scale 8 indicate these individuals' damaged self-esteem, and their striving for achievement suggests a need to prove themselves and to win their parents' love. They tend to be highly competitive, and the success of siblings or close friends tends to make them panic about their own progress. In relationships, they need a great deal of reassurance and often are threatened by their partner's other relationships.

Symptoms and Behaviors

The 89/98 code suggests persons who are highly energetic, perhaps to the point of hyperactivity.

They will be emotionally labile, tense, and disorganized, with the possibility of delusions of grandeur sometimes with a religious flavor, especially if Scale 6 is also elevated. Their thought processes are likely to be tangential and speech bizarre, possibly characterized by neologisms, clang associations, and echolalia (check the BIZ/Bizarre Mentation scale). Their goals and expectations will be unrealistic; they often make extensive plans that are far beyond their ability to accomplish. Thus, their aspirations will be significantly higher than their actual achievements. Usually, they will have severe symptoms related to insomnia. Serious psychopathology is likely to be present. The most frequent diagnosis is schizophrenia, or possibly a schizoaffective disorder with manic states. In addition, a severe personality disorder is a diagnostic consideration. Sometimes, the relative elevation of *F* can be used as an index of the relative severity of the disorder.

Personality and Interpersonal Characteristics

Their interpersonal relationships are childish and immature, and they will usually be fearful, distrustful, irritable, and distractible. Although they might be highly talkative and energetic, they will also prefer to withdraw from interpersonal relationships. They will resist any deep involvement with other people. While on the one hand they are grandiose and boastful, underneath they will have feelings of inferiority and inadequacy. When they do become involved with people, they demand considerable attention and become hostile and resentful when their needs are not met (check the ANG/Anger scale).

- o Self---centered, infantile in expectations of others; demands much attention; becomes resentful and hostile when demands are not met; fears emotional involvement; avoids close relationships; socially withdrawn and isolated; especially uncomfortable in heterosexual relationships; poor sexual adjustment

- o Hyperactive; emotionally labile; agitated, excited; loud, excessive talk; unrealistic in self---appraisal; grandiose, boastful, fickle; vague, evasive, and denying in talking about difficulties; may state no need for professional help; high need to achieve and pressure to do so; performance tends to be mediocre; feels inferior, inadequate; low self---esteem; limited involvement in competitive or achievement---oriented situations

- o Serious psychological disturbance (especially if both scales grossly elevated); most common diagnosis is schizophrenia (catatonic, schizo---affective, paranoid); severe thinking disturbance may be present; confused, perplexed, disoriented; feelings of unreality; difficulty in thinking and concentrating; unable to focus on issues; odd, unusual, autistic, circumstantial thinking; bizarre speech (clang associations, neologisms, echolalia); delusions, hallucinations; sometimes found for adolescent drug users

The majority of individuals with this high point pair show evidence of paranoid mentation and a formal thought disorder. Onset is typically acute and accompanied by excitement, disorientation, and general feelings of perplexity. Well-established autistic trends, delusions, and hallucinations are likely. Regression is manifested by retarded and stereotyped thinking and by emotional inappropriateness. Individuals with this high point pair tend to be narcissistic and infantile in their expectations of others, and become extremely resentful and hostile when their demands for attention are not met. They appear hyperactive, easily distractible, labile, and show grandiose thinking. They are quite unpredictable in their behavior and may act out unexpectedly. Psychotherapeutic intervention may prove extremely difficult because individuals with this high point pair are rather vague and evasive and tend to shift rapidly from topic to topic, so that addressing a specific issue is difficult. While the modal diagnosis for individuals with this high point pair is schizophrenia, manic disorders and drug-induced psychoses should also be considered.

o Moderate to severe excitement, hyperactivity, hyper-talkativeness, flight of ideas, loudness, impulsivity, anxiety, tension, agitation, restlessness, and vulnerability to panic. Severe emotional and behavioral undercontrol. Mood is inflated, even exalted, but labile and unstable, becoming quickly and often unpredictably irritable, hostile, and paranoid. Ruminative, obsessive, and overideational, with fantasizing or daydreaming, often on religious or sexual themes. Quick to disorganize under stress. Manifest psychosis and thought disorder are typical and often severe, with emotional inappropriacy; derailment, clang associations, echolalia, neologisms, circumstantiality, tangentiality, autism, and poor reality testing; behavioral disorganization, bizarreness, hallucinations, and delusions of grandeur, persecution, control, or a combination of these. Cognitive impairment is often severe, with problems in attention, concentration, memory, judgment, and lapses in consciousness. At the extreme, may be disoriented, confused, and perplexed, possibly leading to panic and potential assaultiveness.

Identity and self-esteem are brittle and easily threatened, with underlying feelings of inferiority/inadequacy; failure or interpersonal rejection may lead to panic and collapse, and to a risk of impulsive suicide. Interpersonally suspicious and mistrustful, aloof, volatile, demanding, and entitled, with strong needs for attention and admiration. Hypersensitive to heterosexual rejection. Look for history of problems in school, previous hospitalization, substance abuse, interpersonal rejection, failures of achievement/ aspiration or approval, or other stresses.

8-9 See also the 94 combination, p. 225.

1. This is usually a serious pattern, indicating severe psychological disturbances (Carson, 1969).
2. The person may be confused, disoriented, overly verbal, and under tremendous pressure (Caldwell, 1972).
3. People with this pattern are hyperactive and emotionally labile. They may have a high need to achieve but perform poorly. They tend to be uncomfortable in heterosexual relationships and poor sexual adjustment is common (Graham, 1977).
4. These people's problems may center around lack of achievement or impending failure (Caldwell, 1972).
5. This pattern may indicate an identity crisis in which the person does not know who or what he/she is (Caldwell, 1972).
 - a. Onset of the crisis is usually sudden.
 - b. The crisis does not usually last long when the person receives counseling.

6. Other scales usually are elevated with this pattern.
7. Therapy is difficult with these people, because they have a hard time settling down to anything long enough to deal with it (Carson, 1969).
8. Psychiatric inpatients with 8-9/94 pattern are more likely to have hostile-paranoid excitement than patients in general. They also have frequent ratings for flight of ideas, loud voice, labile mood, and unrealistic hostility. They may be quite erratic and have considerable confusion and perplexity. Onset of this behavior frequently is rapid, however there may have been behavior problems in school. For the 8.9 profile increased speech and activity typically are found. With the 94 profile, the patient may not know why he/she is hospitalized (Altman et al., 1973).
9. Marks et al. (1974) found this 8.9/94 pattern in a university hospital and outpatient clinic. They found the pattern usually for females who were characterized by delusional thinking, rumination, anxiety, and agitation. The Marks, Seeman, and Haller book should be consulted for further information concerning this profile.
10. Gilberstadt and Duker (1965) found this 8-9 pattern in a VA hospital male population. A person with this profile tended to be hyperactive and to have confused thinking. He also tended to be tense and suspicious. The Gilberstadt and Duker book should be consulted for further information concerning this profile.
11. VA hospital males with this profile are hyperactive and overideational. They are likely to have persecutory hallucinations and delusions and react to them aggressively (Hovey & Lewis, 1967).
12. Adolescents in treatment with the 8-9/9-8 pattern (Marks et al., 1974) tended to act out and resent authority figures. Those with the 8-9 pattern were tearful and cried openly. Those with the 94 pattern were more demanding. Both groups had rapid talking and movement. The Marks, Seeman, and Haller book should be consulted for further information concerning this pattern.
13. Megargee and Bohn (1979) found a relatively small group (Group Jupiter) of incarcerated criminals with the 8-9/9-8 profile combination. These men tended to do better than one would expect from their backgrounds which were poor. A larger percentage of Blacks were in this group (60%) than in the other

groups and perhaps some of the scale elevations came from that fact. They had a high incidence of drug abuse but low violence and generally did well in prison. However, when they did get into trouble, they had a higher percentage of assaults than the other groups. They had one of the lowest recidivism rates.

14. College male counselees with this pattern are unhappy, confused, and worrying. Females were restless, depressed, confused, lacking in skills with the opposite sex, and in conflict with parents and siblings (Drake & Oetting, 1959).

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Shipley is 104. The onset of this disorder is typically quite rapid, the duration is somewhat shorter than for other codes, and previous episodes of some sort were reported in 60% of the cases.

8-9/9-8

Individuals with this profile code are viewed as self-centered and infantile in their expectations of others; they demand much attention and become resentful and hostile when their demands are not met. However, they fear emotional involvement and avoid close relationships; hence, they are socially withdrawn and isolated and are especially uncomfortable in heterosexual relationships. They also tend to have poor sexual adjustment.

They are hyperactive and emotionally labile, appearing agitated and excited. They demonstrate loud, excessive talk and have unrealistic self-appraisal. Their thoughts are grandiose and boastful, resulting in vague and evasive statements. They are fickle. They avoid talking about their difficulties and may not state a need for professional help. They have a high need to achieve and may feel pressured to do so; however, their performance tends to be mediocre. They often feel inferior and inadequate and have a low self-esteem. They show limited involvement in competitive or achievement-oriented situations.

A serious psychological disturbance is likely. The most common diagnosis is schizophrenia (catatonic, schizoaffective, or paranoid). A severe thinking disturbance may also be present, resulting in the patients feeling confused, perplexed, and disoriented. They also have feelings of unreality and a difficulty in thinking and concentrating. They are unable to focus on issues and experience odd, unusual, autistic, circumstantial thinking. Bizarre speech (clang associations, neologisms, echolalia), delusions, and hallucinations may be symptoms of these patients. This profile is sometimes found in adolescent drug users.

89/98

Persons with the 89/98 code type tend to be rather self-centered and infantile in their expectations of other people.

They demand a great deal of attention and may become resentful and hostile when their demands are not met.

Because they fear emotional involvement, they avoid close relationships and tend to be socially withdrawn and isolated. They seem especially uncomfortable in heterosexual relationships, and poor sexual adjustment is common.

89/98 persons also are characterized as hyperactive and emotionally labile. They appear to be agitated and excited, and they may talk excessively in a loud voice. They are unrealistic in self-appraisal, and they impress others as grandiose, boastful, and fickle. They are vague, evasive, and denying in talking about their difficulties, and they may state that they do not need professional help.

Although 89/98 persons have a high need to achieve and may feel pressured to do so, their actual performance tends to be mediocre. Their feelings of inferiority and inadequacy and their low self-esteem limit to an extent to which they involve themselves in competitive or achievement-oriented situations. The 89/98 code type is suggestive of serious psychological disturbance, particularly if scales 8 and 9 are grossly elevated. The modal diagnosis for 89/98 persons is

schizophrenia. Severe disturbance in thinking is likely. 89/98 individuals are confused, perplexed, and disoriented, and they report feelings of unreality. They have difficulty concentrating and thinking, and they are unable to focus on issues. Thinking also may appear to be odd, unusual, autistic, and circumstantial. Speech may be bizarre and may involve clang associations, neologisms, and echolalia. Delusions and hallucinations may be present.

Most Descriptive

- 40. Genotype has schizoid features (9.0) +
- 104. Delusional thinking is present (9.0) +
- 24. Spends a good deal of time in personal fantasy and daydreams (8.8) + +
- 58. Tends to be ruminative and overideational (8.8) +
- 74. Utilizes regression as a defense mechanism (8.8) + + +
- 57. Seems unable to express own emotions in any modulated adaptive way (8.6) +
- 96. Genotype has paranoid features (8.6) +
- 44. Is distrustful of people in general; questions their motivations (8.4) +
- 19. Is unpredictable and changeable in behavior and attitudes (8.2) + +
- 45. Thinks and associates in unusual ways; has unconventional thought processes (8.2) +
- 68. Keeps people at a distance; avoids close interpersonal relationships (8.2) +
- 87. Is afraid of emotional involvement with others (8.0) +
- 99. Is stereotyped and unoriginal in approach to problems (8.0) + + +
- 17. Utilizes projection as a defense mechanism (7.8) +
- 85. Has inner conflicts about sexuality (7.8) +
- 103. Reports difficulty in thinking; can't concentrate (7.8) +
- 14. Utilizes acting-out as a defense mechanism (7.6) +
- 106. Has grandiose ideas (extreme is delusions of grandeur) (7.6) + +
- 62. Exhibits evidence of narcissism (latent or manifest) (7.4) +
- 100. Obsessive thinking is present (7.0)

Least Descriptive

- 42. Is "normal," healthy, symptom free (1.0) —
- 108. Has the capacity for forming close interpersonal relationships (1.0) —
- 63. Has a resilient ego-defense system; has a safe margin of integration (1.2)
- 107. Would be organized and adaptive when under stress or trauma (1.2) —

- 37. Defenses are fairly adequate in relieving psychological distress (1.4) —
- 25. Presents a favorable prognosis (1.6) —
- 41. Has good verbal-cognitive insight into own personality structure and dynamics (1.6) —
- 105. Manifests hypochondriacal tendencies (1.6)
- 30. Has "diagnostic" insight; awareness of the descriptive features of own behavior (2.0) —
- 9. Presents self as being physically, organically sick (2.2) —
- 7. Psychic conflicts are represented in somatic symptoms (2.4) —
- 49. Appears to be poised, self-assured, socially at ease (2.4)
- 51. Exhibits good heterosexual adjustment (2.4)
- 95. Accepts others as they are; is not judgmental (2.6)
- 50. Has a need to affiliate with others (2.8) —
- 59. Is socially extroverted (outgoing) (2.8)
- 67. Is able to sense other person's feelings; is an intuitive, empathic person (2.8)
- 69. Gets along well in the world as it is; is socially appropriate in own behavior (2.8)
- 4. Has a need to think of self as an unusually self-sufficient person (3.0)
- 11. Is cheerful (3.0) +
- 101. Utilizes intellectualization as a defense mechanism (3.0) —

Description:

Narcissistic, hostile, interpersonal problems, outbursts of anger or exuberance, hyperactive, high need to achieve, inability to keep attention on one subject, if schizophrenic may have odd/pressed speech, hallucinations, confusion, prognosis is poor

Possible Diagnoses:

Acting out, Substance abuse, Agitated catatonic schizophrenia, Brain damage, Depression, Schizoaffective, Disorganized/Paranoid schizophrenia, Mania, Bipolar/Dysthymic dis.

Modifying Scales

- When Scale 3 is coded third, there is more approval seeking drive and hysterical role playing.
- When Scale 6 is coded third, the possibility of a schizophrenic or manic breakdown is more likely. Paranoia and hostility increase.

- The relative elevation of Schizophrenia (Sc) subscales can hone the 8-9 code type interpretation. Usually, all the Sc subscales are elevated. However, if Bizarre Mentation (BIZ), Psychoticism (PSYC), or Aberrant Experiences (RC8) are elevated, this predicts the possibility of a psychotic breakdown, especially if Psychotic Symptomatology (BIZ1) exceeds Schizotypal Characteristics (BIZ2).
- When Depression (DEP) is elevated, they may experience rapid mood fluctuations.
- When Antisocial Practices (ASP) or Antisocial Behavior (RC4) are elevated, even if Scale 4 is not, the profile may reveal bizarre and antisocial acting out.
- Typically, Anger (ANG) is elevated, reflecting their explosive irritability.
- Elevations on Anxiety (ANX), Obsessiveness (OBS), Fears (FRS), Low Self-Esteem (LSE), and Type A Behavior (TPA) would indicate one or more of the following: anxiety, obsessiveness, fearfulness, low self-worth and drive.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Males

Low 0 Lacks knowledge or information, lacks academic motivation, aggressive or belligerent. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, shyness in the interview, being nonresponsive or nonverbal, being nonverbal or a nonrelator, indecisiveness.

Low 6 Rationalizes a great deal.

Nothing Low Indecisive, unhappy, worries a great deal, insomnia, confused.

- Note: Scale 9 coded high was infrequently associated with indecisiveness and worrying a great deal.

Females

Low 0 Restless, resistant in the interview, verbal, confused, 8- conferences, socially extroverted, marriage oriented.

- Note: Scale coded low was infrequently associated with confusion.

Low 1 Restless, resistant in the interview, verbal, confused, 8+ conferences, socially extroverted, vague goals.

Low 2 Restless, exhaustion, resistant in the interview, verbal, confused, 8+ conferences, socially extroverted.

- Note: Scale 2 coded low was infrequently associated with confusion.

Low 3 Restless, resistant in the interview, verbal, confused, 8+ conferences, vague goals.

Low 4 - Restless, resistant in the interview, verbal, nonresponsive, confused, 8 + conferences, shy in the interview.

Low 5 - Restless, anxieties, exhaustion, resistant in the interview, verbal, wants answers, confused, 8+ conferences, distractible in study.

- Note: Scale 5 coded low was infrequently associated with resistance in the interview.

Low 6/7 Restless, resistant in the interview, verbal, confused, 8+ conferences.

Nothing coded low - Restless, depressed, resistant in the interview, verbal, confused, 8+ conferences, father conflict, mother conflict, sibling conflict, lacks skills with the opposite sex

(Drake & Oetting, 1959)

o **Check:** *RC9, DisOrg, CogProb, RC8, ANX, DEP1, DEP3, DEP4, HEA2, BIZ1, BIZ2, ANG1, ANG2, CYN1, CYN2, ASP1, TPA2, FAM1, AGGR, PSYC, DISC, NEGE, Dr1, Dr4, Dr5, Hy2 (low), Hy3, Hy5 (low), Pd1, Pd4, Pd5, Pa1, Pf1, Pf2, Pf3, Pf4, Pa2, Pa3 (low), Sc1, Sc2, Sc3, Sc4, Sc5, Sc6, Ma1, Ma2, Ma3, Ma4, Si2 (low), A, R (low), Re (low), MAC-R, AAS, MDS.*

TREATMENT

Initially, treatment should focus on controlling the mania, which will diminish the psychotic symptomatology. A bipolar disorder should be considered. These individuals lack insight and resist psychological interpretation out of fear that they would be judged as defective. They need structure and support, as well as medication to manage the psychotic and manic symptomatology. In therapy, they develop a rapid transference, with demands on the therapist, perhaps recapitulating childhood yearnings to be favored, to undo their experience of feeling put down or disfavored. Look for childhood conditioning experiences of parents who demanded a great deal of success, but could treat the child with coldness or hostility when displeased. Self-esteem building in a structured environment would be most appropriate. Help them develop realistic goals for themselves and a more realistic view of their achievements. They are extremely self-critical. Supportive therapy to help them reconstitute and feel less panicked is more useful than insight therapy.

Treatment: Rule out Bipolar Disorder, Manic; Schizoaffective Disorder (excited); sympathomimetic toxicity; “homosexual panic” (8-9-5/9-8-5). Severe lack of insight and resistance to psychological approaches. Biological therapies initially effective despite resistance to medication. Easily threatened by psychotherapy and prone to negativism and evasiveness. Needs high level of structure and support, with focus determined by patient.

- Frequent diagnoses: schizophrenia, schizoaffective disorder with manic states, severe personality disorder; the relative elevation of F can be used as an index of severity. (Groth-Marnat, 2009)

Treatment Implications

Because they are highly distractible and tangential, psychotherapeutic approaches with them are extremely difficult. Furthermore, their level of insight is poor, they resist psychological interpretations of their behavior, and they cannot focus on any one area for any length of time. A frequent defense is denial of any psychological problems along with grandiose thoughts and an inflated sense of their self-worth. Challenging these defenses is likely to provoke irritability, anger, or even aggression. If extensive delusions and hallucinations are present, antipsychotic medication may be indicated. Lithium may be useful if the mood component of their disorder predominates.

Therapy and Therapeutic Pitfalls

It is important to rule out bipolar disorder and suicidal ideation. Medication is almost always necessary to deal with their cognitive disorganization and hypomania. The 8-9 code types, however, are suspicious and fearful of medication. Their use of chemical agents is often an issue, and compliance therapy can be used to address both medication and substance abuse issues (Greenberger & Kemp et al., 1996).

These clients need a great deal of structure and concrete problem solving. Self-esteem building, relaxation techniques (Chen et al., 2009), cognitive therapy (Padesky, 1995), rational emotive therapy (RET; Ellis, 1993), and thought stopping can be helpful. Therapy can provide reality testing to help them identify their own goals rather than living up to parental expectations. In long-term therapy, help the clients recall instances in childhood where they felt they were unappreciated relative to other siblings, and help them to understand how they have internalized a negative self-image. Help them to recognize when others' successes led them to catastrophize their own perceived failure. These clients can develop an intense, positive transference to a therapist, replicating their longings for approval from a parental figure. However, this transference can quickly turn negative if they perceive the therapist as critical or demanding of them. These clients want the therapist's approval and look for any sign that they are disfavored relative to the therapist's other clients. Structure is important, as they question and resist boundaries. (Levak, Siegel, Nichols, & Stolberg, 2011)

Treatment and Self-Help Suggestions

1. Talk to your therapist about the possibility of taking medication that can help calm your moods and your confusion and can help you to sleep better and feel more rested when you awaken. It is important that you

and your therapist talk openly about any concerns you have.¹

2. Work with your therapist to discover what has happened recently that's left you feeling rejected, inadequate, or defective. In your therapy identify any "schemas" or themes that you developed in dealing with your childhood experiences.² Some common themes include the belief that you are damaged, or the belief that others will somehow hurt you or put you down. In the therapy session, imagine a conversation with the person that feeling involves. Being able to express the emotions in the safety of the therapy setting can gradually help you learn new perspectives and challenge these old schemas.³
3. You may be feeling vulnerable to criticism and rejection from others. Make a list of all your accomplishments and experiences that you could be proud of so that you don't focus so much on your failures. If you need help identifying your strengths and accomplishments, you will find helpful questionnaires at the Web site www.authentichappiness.sas.upenn.edu.
4. Explore with your therapist why you are so perfectionistic and why you demand so much from yourself. Whose love are you trying to win? What's it going to take for you to like yourself and stop pushing yourself so hard?
5. Examine any irrational beliefs that may be at the root of your desire to do everything perfectly. Such irrational beliefs are often signaled by such words as *should*, *must*, or *have to*. For example, "I should never make mistakes," or "Everyone must like me." Ask yourself (1) Where is the proof that this belief is true? (2) Is my irrational belief helping me or making things worse? (3) Is this belief logical, and does it make common sense?⁴
6. If people seem hostile, controlling, or rejecting, remember that you are feeling particularly knocked off balance right now and that, in fact, people may not be looking at you in the negative way you think they are. Remember, people are often preoccupied, insensitive, and are thinking about themselves, and are not necessarily feeling critical of you. See if you and your therapist can identify any fear-based types of "distorted thinking" that may contribute to you feeling this way, and then work to challenge those beliefs that are no longer helpful. One type of distorted thinking is called "personalizing." An example might be assuming that because someone looks irritated or seems angry it is because of you. A more helpful way of thinking would be that the person had a bad day or is distracted.⁵

7. While you're going through this agitated, hyperactive state, avoid chemical agents as they have a tendency to disorganize you further.
8. Exercise, especially aerobic exercise, and diet can help reduce stress and also can help improve your mood. Try to incorporate a regular program of exercise into your daily routine.⁶ Supplements and a diet rich in Omega-3 fatty acids may also help stabilize your mood.⁷
9. Work with your therapist to develop thought-stopping techniques so that you can slow your mind down. Recognize when your mind is racing so that you can learn to slow it down and focus on one thing at a time. Thought stopping is an effective technique you can practice to help you prevent the types of unwanted thoughts that can make you feel distracted. Several forms of thought stopping are effective. One quick technique involves picturing or saying out loud, "Stop," whenever experiencing these types of unwanted thoughts. You then replace the thought with a pleasant image or affirmation that is more positive (e.g., "I have felt this way before, and I know I can handle this").

¹ Compliance therapy combines principles of motivational interviewing, inductive questioning, reflective listening, and reinforcing adaptive behaviors and attitudes to explore client ambivalence and target medication adherence (Kemp et al., 1996).

² Schema therapy has been demonstrated to be an effective treatment for clients who expect and anticipate emotional rejection and criticism based on their own early childhood conditioning experiences. Help the clients first identify their particular schema (Bricker & Young, 2004), and then work to help them examine the early experiences that led to that belief. The next step is to challenge that idea and help them examine whether it is true and whether it is helpful (Young, Klosko, & Weishaar, 2003).

³ Schema therapy uses many of the same methods of cognitive behavioral therapy, but it adds imagery to uncover suppressed emotions and to highlight the ways that these fixed beliefs affect current relationships (Young, 1999).

⁴ Rational emotive therapy is a treatment that can guide people to see how their beliefs are needlessly disturbing them; to work at self-defeating emotional, cognitive, and behavioral problems that result from irrational thinking; and ultimately to achieve self-fulfillment and self-actualization. An excellent summary of the current state of RET can be found in the *Journal of Consulting and Clinical Psychology* in an article titled "Reflections on Rational-Emotive Therapy" (Ellis, 1993).

⁵ *Mind Over Mood* (Greenberger & Padesky, 1995). This workbook contains exercises such as thought stopping and keeping a thought record to overcome negative and destructive thinking.

⁶ Results of cross-sectional and longitudinal studies consistently find that aerobic exercise has antidepressant

and anxiolytic effects. It also can protect against harmful effects of stress (Salmon, 2001).

⁷ There is promising evidence that Omega-3 fatty acids can help control some types of depression and mania (Osher, Bersudsky, & Belmaker, 2005; Turnbull, Cullen-Drill, & Smaldone, 2008).

(Levak, Siegel, Nichols, & Stolberg, 2011)

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests you are feeling intensely energized. You may have experienced a recent setback, perhaps a rejection by someone you cared about or a perceived failure that has left you feeling extremely agitated and anxious. You tend to be your own worst critic and you are currently experiencing a great deal of anxiety because you feel that you are a failure, are not good enough, and that the people you want to care about you will not, because you have somehow failed. You are so “wound up” it is hard for you to finish your sentences, switch off your mind, or even fall asleep when it is time to do so. You may find yourself fantasizing about doing great things, perhaps feeling that you have a special religious calling, or that somehow you have important messages to give to the world. If you have recently been taking any kind of drugs, you may be responding to their effects by becoming extremely agitated and overactive. If, in fact, you have experienced some blow to your self-esteem, this may have precipitated your current crisis. You are spending a lot of time thinking about your failures and how you need to prove yourself by doing something exceptional. However, you may find your mind racing, so that it is hard to focus and finish the things you start. Feeling this high level of tension, you might easily become irritated and angry if people get in your way or disagree with you about your insights and visions for how things should be. You may also be experiencing periods of paranoia, where you feel unsafe because you feel others are critical of you, trying to control you, or are out to get you. In some cases, people with your profile grew up with parents who demanded achievement and success, but also at times could be cold or cruel, perhaps favoring a sibling over you. You may have felt particularly controlled and, at the same time, treated unfavorably as compared to your other siblings. No wonder some recent setback could have precipitated in you a panic about your identity and a feeling that you need to do great things in order to be loved. Your therapist may want to suggest medicine to calm down your extremely high energy and feelings of panic and anxiety. Work with your therapist at seeing yourself more clearly so that you can switch off your constant self-critical thoughts. Set realistic goals for yourself and try to stick to them. Be aware that you get easily interrupted and distracted because, no matter what you are doing, you feel that maybe something more important needs to be done first. Use mindfulness therapy to observe your emotions and label them so that you can learn to express your feelings to others. Watch your tendency to interrupt others and finish their sentences or to interrupt yourself and switch from topic to topic. Learn to finish your sentences and stick to one topic until you finish exploring it.

Feedback Statements—Elevated Profiles (T-Score > 65)

Strengths

Your profile shows that you have a number of significant strengths. You have a great deal of energy, drive, and ambition. Your mind works quickly, and you readily see the connections between things. You are also a person with very high personal standards, and it's important for you to be perfect in everything you do. Typically, people with your profile have a very rich imagination, and it's easy for you to fantasize, daydream, and come up with creative and interesting ideas.

Confused, Disorganized, Hypomanic

Currently, you appear to be knocked off balance and quite confused. You may feel somewhat out of control and disorganized, and at times you may not make sense to others. You have a great deal of energy, and your mind may be racing so quickly that it's hard for you to stay focused and to think clearly. In fact, your energy may be so high that it is affecting how you feel, how you think, and what you do in negative ways. You might be seeing the connection between things to such a degree that you are overthinking and not seeing reality clearly.

Agitated, Explosive, Paranoid

You may be experiencing periods where you feel agitated, wound up, and even explosive. You might be going through periods of paranoia, wondering if people are being critical, discounting, or rejecting of you.

Perfectionist or Needs for Achievement

You have always been a perfectionist with a strong need to prove yourself. You have a tendency to take on many projects, to push yourself, and to feel you have to achieve a great deal to gain other people's love and recognition. You are quite competitive, and it upsets you when others do well because you feel you are falling behind.

Self-Doubt

Currently, you seem to be doubting yourself, wondering if you are good enough or if people are going to see you as somehow unworthy. You may be going through a very self-critical period, beating yourself up, and telling yourself that you have failed.

Overly Active or High-Strung

During these times, you might get quite panicked, overly active, and high-strung. When things go wrong or when someone criticizes you, you doubt yourself to the core, wondering if there is something wrong with you. It's hard to relax and to quiet down your inner voice. You are probably feeling a great deal of pressure to explain your ideas and to convince people that you are seeing things clearly.

Lifestyle and Background Feedback

Often, people with your profile grew up as middle children. Perhaps your parents were very demanding and expected great things from you, so you felt you were disappointing them. When they were dissatisfied, they may have made you feel defective, unlovable, and or inferior compared with your siblings. Perhaps one of your parents was controlling, demanding, and at times unreasonably critical. You wanted your parents' love and approval, yet somehow you felt it was impossible to get. In school, you might have played with younger children, perhaps because you felt more comfortable in situations where you could be in control. However, you may have been seen by your peers as a little too aggressive or perhaps even bossy. You have always driven yourself hard, wanting to achieve and succeed, possibly as a way of proving that you were worth loving.

Normal-Range Feedback (T-Score 50 to 65)

Your profile is in the average range. You are a creative, energetic, and ambitious person who has an unusual way of looking at and solving problems. Your profile suggests that you may be going through an evaluation of your identity search, perhaps thinking about future goals, plans, and possible changes in your lifestyle. This may be due to a recent letdown or perceived failure that leads you to question what you are doing and where you are going in life. Generally you are an active person who can work on a number of problems and projects at the same time. You can be quick to judge yourself for any mistakes or failures. While having such high standards for yourself may be a positive thing, it also may mean that when things don't go as you planned you are overly harsh and disappointed with yourself.

(Levak, Siegel, Nichols, & Stolberg, 2011)

896F Code

This pattern was found in a group of rural, isolated, Black males (Gynther, Fowler, & Erdberg, 1971).

80/08 Codes

Markedly aloof and socially withdrawn, these individuals are very uncomfortable in interpersonal relations and avoid social interaction. They tend to spend a great deal of time in personal fantasy, and their social isolation often extends to alienation from their families. They tend to describe themselves as depressed and anxious, and most

report anhedonia. They describe their family life as conflicted and unsatisfying, and report having trouble making decisions because they worry that others will be critical of them. They are easily frightened and many have phobias. Extremely uncomfortable in any type of social setting, they tend to give up easily when frustrated, and avoid conflict whenever possible. Typically, they also feel worried, indecisive, and misunderstood by others. They often feel confused about what is bothering them or what they want or expect from others, and they lack assertiveness. In counseling sessions, they are likely to be largely nonverbal. They doubt therapy will work for them, and have difficulty disclosing personal information. If a third scale is elevated within five *T*-score points of Scale 8 or 0, it is often helpful to temporarily ignore the elevation of Scale 0 and to interpret any two-point codetype that results. Scale 7 or 2 is most often the third highest scale elevation in this codetype.

8-0 See also the 0-8 combination, 13. 232.

1. Marked withdrawal and people avoidance is most likely with this pattern (Lachar, 1974).
2. VA hospital males with this combination are worried, confused, and indecisive (Hovey & Lewis, 1967).
3. College counselees with this pattern tend to be nervous and nonverbal as well as introverted and shy. They tend to be poor communicators in counseling sessions (Drake & Oetting, 1959).

o Dysphoria, inertia, anhedonia, impaired self-esteem, guilt; problems in concentration, memory, judgment, and decision making; autistic thinking; severe alienation, aloofness, social anxiety, timidity, and avoidance; and suspiciousness. Easily frightened. Avoids conflict and gives up in the face of difficulty. Check third highest scale.

Description:

Socially avoidant, nonverbal, indecisive, isolated, show anxiety and escape into fantasy

Possible Diagnoses:

Schizoid p.d., Avoidant p.d., Schizophrenia

TREATMENT

Because they generally are non-communicative, psychotherapeutic relationships are initially difficult. Therapist patience, without pushing the patient to speak, and a structured environment with life skill training are most useful. Gentle, supportive, esteem-building psychotherapy, along with assertiveness and social skill training, can be useful once a therapeutic alliance is developed. These clients are sensitive to anything that might be construed as criticism.

Establishing rapport can perhaps be done by asking them general non-threatening questions about what foods they enjoy, or personal habits, being careful to not appear critical or “looking for what’s wrong.” Dialectical behavior therapy is useful. These individuals tend to be emotionally and socially isolated, so they lack the basic skills of relating to others; thus, even rudimentary rapport building can be therapeutic.

THERAPEUTIC FEEDBACK LANGUAGE

See feedback for Spike 8 and feedback for Spike 0.

Scale 9: Hypomania (Ma)

Descriptors

Complaints

Possibly manic, overactive, overcommitted, poor judgment, irritability or temper outbursts, excitability, possible substance abuse, impulsivity, garrulousness, possible promiscuity, hyperactive behavior

Thoughts

Optimistic, positive, enterprising, grandiose, flight of ideas, tangential thinking, overinclusive, ebullient, possible hallucinations and delusions, self-important, messianic beliefs, opinionated, creative

Emotions

Labile, sunny and positive, optimistic, grandiose, impatient, enthusiastic, energetic, impulsive, excitable, uninhibited, episodically irritable, hostile, aggressive, or depressed

Traits and Behaviors

Upbeat, positive, highly energetic, ambitious, driven, buoyant, jocular, approval seeking, garrulous, exuberant, overcommitted, unrealistic, irritable, disorganized, demanding, distracted

(Levak, Siegel, Nichols, & Stolberg, 2011)

Therapist's Notes

In the normal range, Scale 9 clients are optimistic, positive, sunny, driven, and energetic. Ambitious, with needs to prove themselves, they have a tendency to overcommit and set unrealistic goals for themselves and others. They are big-picture thinkers and often are quite productive. Easily bored and distracted, they occasionally experience problems because of inattention to detail. Impatient with people who get in their way, they are stimulation seekers. Most of the time, however, they exhibit an agreeable, even charismatic, disposition.

(Levak, Siegel, Nichols, & Stolberg, 2011)

o Inflated, expansive, and euphoric mood, with hyperactivity, hyper-talkativeness, excitement, pressured speech, grandiosity, flight of ideas, impulsivity, jocularity, and fearlessness. Mood is relatively stable but may become quickly hostile when frustrated, thwarted, or rebuffed. Very intolerant of external controls and limitations.

Thinking varies from fairly well organized though unrealistic (hypomania) to disorganized, fantastic, and bizarre (mania). Dress and grooming may be loud, conspicuous, and flamboyant. Tend to be involved in multiple projects and plans to which they attach messianic importance and to which they may devote themselves to the extent of going without sleep. Cognition is experienced as completely unfettered, with racing thoughts and effortless decision making, but may appear to others as circumstantial, prodigal, and impulsive. Grandiosity may have a religious complexion, with exaltation and “world-saving” or iconoclastic fantasies/delusions. Interpersonally promiscuous and outgoing but with poor empathy and suspicions/fears that others will not recognize, appreciate, or confirm patient’s inflated identity; quick to feel invalidated. Look for family history of mood disorder, history of previous manic or depressive episodes requiring hospitalization, substance abuse, return to baseline functioning after previous episodes, interpersonal rejection, failures of achievement/aspiration or approval, or other stresses.

Elevations on Scale 9 are associated with a high level of energy and activity. Even if appearing relaxed, they will report a great deal of internal cognitive activity. High 9 individuals can appear buoyant, cheerful, and charismatic; however, when frustrated they can quickly become hostile, angry, demanding, and confrontational. They are not always manic, but overactivity, overcommitment, unrealistic goal setting, and irritability are common. Flight of ideas, pressured speech, a hostile, joking humor, and grandiosity characterize individuals with an elevation on Scale 9. They are highly competitive and threatened by others’ successes and have strong needs to achieve. They tend to work in spurts of energy, allowing tasks to accumulate then becoming productive in a demanding, irritated, and controlling fashion. As Scale 9 elevations increase, it reflects disorganization, distractibility, and grandiose, unrealistic goal setting. A reduced need for sleep, rapid weight changes, and the use of chemical agents as a way of medicating and managing energy are associated with high elevations. These individuals’ increased energy can manifest itself in flight of ideas and grandiosity, increased sexual drive, and overcommitment. Elevations on Scale 9 do not always reflect mania, and elevations do not correlate perfectly with the degree of disturbance.

Sometimes moderate elevations on Scale 9 (T-score 65 to 75) may reflect a manic episode with psychosis, and in other cases higher elevations of Scale 9 are a sign of hypomania rather than mania. Precipitating circumstances are usually a perceived or actual failure or a grandiose overcommitment. These individuals tend to have poor judgment, are intolerant of frustration, and intimidate others with their temper and the intensity of their demands. Many bright high 9s are extremely successful, blazing new trails in business, finance, and politics. Their success improves

when they surround themselves with methodical, detail-oriented types to protect them from hasty, poorly thought through actions. In other cases, their mania is clearly evident, with occasional disastrously poor judgment. Most high 9

individuals are easily bored and impatient with details and strongly resist being controlled. They are liable to be narcissistic and opportunistic and tend to exploit situations created by others' mistakes and vulnerabilities, though they are not necessarily sociopathic, unless Scale 4 and Antisocial Practices (ASP) or Antisocial Behavior (RC4) are elevated. Although often highly social, they have difficulty being vulnerable and intimate. As partners, they are initially seen as attractive but eventually become controlling, irritable, and demanding.

Individuals with low scores on Scale 9 exhibit some of the opposite attributes associated with high 9 code types. In the presence of Scale 2 elevations, a low 9 may reflect the depressive side of a bipolar disorder. Sometimes, medical problems (e.g., thyroid) may be the source of low energy. In the absence of any clinical scale elevations, a low score on Scale 9 may reflect reliable, orderly individuals who are careful not to overcommit and tend to be persevering and emotionally stable.

Spike 9 individuals exhibit symptoms of hypomania and, in some cases, mania. They are energetic, excitable, over-productive, and exhibit pressured speech and superficial charm, together with a hostile, joking humor, and quick-tempered irritability if thwarted. Spike 9 individuals can often be extremely productive and successful, although impulsive behavior and lack of attention to detail can lead to self-defeating behavior.

Spike 9 individuals dislike being controlled or limited, and they are often talkative, if not garrulous. Their thought processes can vary, sometimes in close proximity, from being well-organized, pressured, and somewhat grandiose, to disorganized and manically bizarre. They enjoy attention, speak with a loud-pressured voice, and readily switch topics in response to others' interests. Some are flamboyant. They tend to overcommit to tasks and activities, and they work in spurts of energy. When Spike 9 elevations are associated with mania, grandiosity with a religious flavor or messianic political fantasies and delusions can be present. Reduced sleep, and drug and/or alcohol use as way of medicating the hypomania are also common.

High-Point 9's

In the Minnesota normative samples, scale 9 is the most frequent peak score for both males and females, but it should be noted that scale 5 was not included in these tabulations. In the younger Minnesota subjects in the samples

from the ninth-grade studies, Hathaway and Monachesi (1963; see Appendix M) included both scales 5 and 9 and still the peaks on scale 9 were the most prevalent for males and were second only to scale 4 in the female tabulations. At the college level, 9 peaks are the most frequent high point in women and run second only to scale 5 in men. In the various deviant populations reported in Appendix M, scale 9, while always contributing a substantial proportion of high points, does not compete for the highest ranks. Sutton (1952) found that for psychiatric groups the most frequent low point in the codes was on scale 9. Ratings by Others. Black reported that the normal college women with peak scores on scale 9 were seen by their peers as enterprising, energetic, persevering, and idealistic. This high activity level does not appear to be well controlled, however, because these women were also judged to be awkward and infantile, boastful and show-offs, selfish, self-centered, and inflexible. Similarly in their omissions the peer raters reflected the same theme. They did not characterize the high 9 girls as mature, loyal, or popular. These girls had few aesthetic interests, nor did they impress others as honest or peaceable. The raters also omitted the terms unself-controlled and seclusive to a significant degree.

Mello and Guthrie found that the college counselees with peak scores on scale 9 did not often show a hypomanic picture in their presenting complaints when seeking help. They were most frequently concerned with personal relationships stemming from problems in the local college setting. The men often showed concern over homosexual tendencies while the women were more preoccupied with their aggressive impulses. These counselees also described themselves as rebelling against dominant parents. In the course of treatment the high 9 students were resistant and irregular in attendance, and frequently terminated their therapy very early. Mello and Guthrie reported that the resistances took the form of intellectualization, changing the subject, and repetition of their problems in a stereotyped manner. They did not become dependent on the therapist but remained guarded and hostile in their relations with him. Drake made the general observation that when 9 is the peak score in college counselees, other traits are expressed in a more energetic fashion than when the scale is low. Self-Ratings. The women that Black studied gave a long list of descriptive terms in the checklists they completed on themselves. While most of these terms are socially favorable and self-enhancing, a few of them are quite critical. They said they were jealous, aggressive, and flattering. They omitted using such terms as reliable, generous, and clear-thinking to a significant degree. They viewed themselves (as did their peers) as enterprising and energetic, to which they added such terms as enthusiastic, decisive, self-confident, and sociable in the sense of mixing well. Whereas the peers of these girls perceived them as quite immature, the high 9 girls saw themselves as polished, sophisticated, poised, and worldly. They said they were independent and individualistic, not conventional or dependent. They appeared to deny inner tensions and discomfort by endorsing such terms as relaxed, peaceable, and contented, and by omitting such terms as indecisive and sensitive. They described their temperament as affectionate, goodtempered, laughterful, and natural. They saw themselves as self-controlled and popular, curious, with aesthetic interests, but not quiet, shy, or

seclusive. They said they were adaptable, versatile, courageous, practical, not unrealistic, and not given to partiality.

See also the 9 prototype in the Gilberstadt and Duker Handbook (the basic defining characteristics of this pattern are given in Chapter 3).

(Dahlstrom, Welsh, & Dahlstrom, 1979)

Moderately high scores (T -60–65) can suggest a well-adjusted energetic, outgoing, and active person who is seen by others as colorful, affable, and charismatic. They are quite achievement-oriented.

Low scores to very low scores ($T < 45$) suggest a lowered energy level, a lack of drive, listlessness, or even apathy. As Scale 9 is elevated, individuals appear increasingly committed to their beliefs, tend to feel that they are more perceptive and see the world more clearly than others. Some may become paranoid, feeling that others are jealous of them or getting in the way of their important world contributions. In cases of hypomania without psychosis, Spike 9 suggests an individual who superficially appears self-confident but is quite insecure and needs a great deal of approval. They tend to extol their own virtues and flatter others in order to elicit flattery in return.

Lifestyle and Family Background

Our hypothesis is that Scale 9 reflects a combination of a genetic predisposition to overactivity and high needs for stimulation and excitement, together with early demands for success and achievement. They are often described by parents as having been active, energetic, and hard-to-manage children who were overly excitable and demanding and had high needs for stimulation. Some may have been diagnosed as hyperactive in childhood and medicated with stimulants. Parents may have attempted to control a demanding, high-energy, distractible child by restriction, thus increasing the child's drive state. In some cases, individuals with an elevated Scale 9 felt a need to restore the family reputation after a family setback, and in some instances parental, social, and economic striving meant that parental approval was contingent upon getting good grades, winning competitions, and earning prestige through continuous accomplishment (Cohen, Baker, Cohen, Fromm-Reichman, & Weigert, 1954; Goodwin & Jamison, 1990). We hypothesize that parental reinforcement was under a partial reinforcement schedule, often only for spectacular success, maintaining the child in a constant high drive state and leading to feelings of vulnerability to rejection around failure.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Description:

Aggressive acting-out in males, extroverted, sociable, no intimacy, high energy level, may show manic or grandiose episodes, impulsive, rebellious, may be anxious, striving to fulfill their ambitions, easily frustrated

Possible Diagnoses:

Substance abuse, Antisocial p.d.

Modifying Scales

- Elevations on Scale 9 energize the behaviors, thoughts, and emotions associated with other scale elevations. For example, elevations on Scale 4, without an elevation on Scale 9, would predict cold, calculating, aloof, and emotionally distant individuals. With the addition of Scale 9, Scale 4 behaviors are “energized,” suggesting impulsive, hedonistic acting out.

- When Scale 2 is elevated, the euphoria and expansiveness of Scale 9 are canceled out by the dysphoria and fears of loss associated with Scale 2. The result is moodiness, emotional lability, tension, anxiety, and irritability.

Rule out bipolar disorder. For more information, see the 2-9 code type.

- Even in the absence of Scale 4 elevations, if Authority Problems (Pd2) and ASP are elevated, acting out similar to a 9-4 code type is suggested.

- When Naïveté (Pa3) is elevated, the opinionated self-righteousness of the high 9 is rigid, black-and-white, and lacking in flexibility.

- When Lack of Ego Mastery Cognitive (Sc3) and Lack of Ego Mastery Conative (Sc4) are elevated and if Bizarre Mentation (BIZ), Psychoticism (PSYC), or Aberrant Experiences (RC8) are elevated, a psychotic manic episode may be present.

- When Type A Behavior (TPA) is elevated, the high 9 impatience and irritability are aggravated by an aggressive competitiveness, impatience, and perhaps hostility.

- When Work Interference (WRK) is elevated, look for hypomanic overactivity and difficulties with follow-through to decrease work efficiency.

■ When Inability to Disclose (TRT2) is elevated, individuals are reporting they don't need help, and dealing with mental health professionals is unlikely to add value to their lives.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Male

- Low 0 Aggressive or belligerent. This pattern was infrequently associated with introversion or self-consciousness or social insecurity, shyness in the interview, being nonresponsive or nonverbal, being nonverbal or a non-relator, indecisiveness.
- Low 6 Rationalizes a great deal.

Female

- Low 1 - Vague goals, socially extroverted.
- Low 2 - Socially extroverted.
- Low 3 - Vague goals.
- Low 4 - Shy in the interview, nonresponsive.
 - o Note: Scale 9 coded high was infrequently associated with shyness in the interview.
- Low 5 - Verbal, exhaustion.
- Low 0 - Marriage oriented, socially extroverted, verbal.

(Drake & Oetting, 1959)

o **Check:** *RC9, AGGR, FRS1* (low), *FRS2* (low), *DEP1* (low), *DEP2* (low), *DEP3* (low), *DEP4* (low), *TPA1* (low), *LSE1* (low), *LSE2* (low), *SOD1* (low), *SOD2* (low), *PSYC*, *RC8*, *DISC*, *INTR* (low), *Dr2*, *Sc2* (low), *Ma1*, *Ma2*, *Ma3*, *Ma4*, *Si1* (low), *Si2* (low), *A* (low), *R* (low), *Re* (low), *GF* (low), *MAC-R*, *AAS*.

TREATMENT

There may be a genetic component to high energy, hypomania, and its extreme, mania. Look for childhood histories of being active or hyperactive, with attempts by caretakers to control them. Caretakers are often constantly motivating the Spike 9 individual to achieve and succeed. In some cases they came from poor backgrounds and felt a need to enhance the family's social standing by their own success. They are very ambitious and the precipitating circumstance tends to be around the perceived failure or an obstacle to their achievement striving. In the presence of

manic symptomatology, medication is recommended. These individuals tend to be difficult to interview because of their denial and evasiveness, and their lack of focus.

The therapist can develop a therapeutic alliance by giving them a great deal of praise and discussing how the intensity of their energy, while admirable, may be interfering with even better productivity. In other words, validate their self-image as needing to be productive and special, and reformulate therapy as helping them manage their intense energy so that it is more productive. Validate how they see the connections between things and their apparent social intelligence.

Once a therapeutic alliance has been established, help them to develop more realistic goals, and to differentiate between what they want for themselves and the internalized expectations of others. Help them control their impulse pressures and their tendency to switch careers or goals. Dealing with their fear of failure is a therapeutic goal.

o **Treatment:** Rule out Bipolar Disorder, Manic; substance abuse. Lack of insight and resistance to psychological approaches. Biological therapies initially effective. May fear depression.

May accept supportive psychotherapy but require assistance to attend sessions.

Treatment and Self-Help Suggestions

1. When other people are speaking, watch your tendency to interrupt or become distracted and think about other things. When you catch yourself interrupting, take a deep breath, and try to listen, slow your thoughts and stay in the present moment.
2. Learn with your therapist how to recognize when you have racing thoughts. The practice of mindfulness is a way for you to channel your high levels of energy and to increase your focus and productivity. Mindfulness involves paying attention to the present moment in a nonjudgmental way and fostering a quality of curiosity and openness.

For more information on mindfulness exercises see www.mindfulnessstapes.com. Engaging in a daily practice of mindfulness can help you redirect your attention instead of going on autopilot.¹
3. At times, your energy may work well for you so you have a great deal of confidence and infectious energy, quickly getting the big picture,² but you can also have trouble concentrating on details. Work with your therapist to develop habits that will help you stay focused. For example, morning is often the best time to take on tasks that require attention. Although many people need a quiet environment to stay on task, you

may find it more helpful to turn on a radio or television so that you have some “white noise.” Giving yourself breaks every hour can also help you to stay focused.

4. In your therapy, see if you can identify any recent events that may have pushed you into this state of heightened activity. Did you experience a recent setback or loss? Have you lost someone important in your life? Did someone else’s success lead you into thinking that you were not successful? Did someone criticize or judge you, or are you anticipating that you’re going to fail at something?
5. Because of your high-energy, racing mind, and your tendency to overcommit, you may need medication to slow you down enough so that you can be productive. Although you may be successful in the shortterm, something is likely to eventually go wrong if you continue to move so quickly. It is important that you and your therapist talk openly about any uncertainty or concerns you have about taking medications.³
6. You have a tendency to overcommit, and you may be unrealistic about what you can actually accomplish. There are many software applications for the computer and cell phone that will help you manage tasks, set priorities, and track important dates. Software packages can be found at <http://www.mylifeorganized.net>.
7. It is important that you engage in physical exercise during this period of high energy. Daily exercise can help you become more relaxed, but don’t overdo it.⁴
8. Avoid chemical agents as a way of medicating your energy. They may actually aggravate your mood swings and lead you to making unpredictable and even dangerous decisions.⁵
9. When you experience surges of irritability and rage, take a moment to stand back from the situation and to calm yourself down. Practicing some type of relaxation exercise on a regular basis can reduce irritability, stress, and anger. Relaxation can lead to a decrease in heart rate, blood pressure, respiration, and muscle tension.⁶ Yoga, meditation, biofeedback, and progressive muscle relaxation are all methods that can help you achieve a state of deep relaxation.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Therapy and Therapeutic Pitfalls

Although suicidal ideation is rare in the manic state, impulsive and reckless conduct is not. These clients can engage in self-defeating and self-destructive behavior, such as driving at excessive speeds, abuse of chemical agents, reckless sexuality, and irritable aggression. Suicide risk increases if clients move from a euphoric to a depressive state subsequent to perceived losses. Medication is usually necessary to control a manic state, although it is often resisted as it interferes with the experience of elation and control (Chou, 2004; Lingam & Scott, 2002). Rarely is treatment sought voluntarily, and often only after legal, interpersonal, or family difficulties.

These clients typically are resistant to insight therapy because of the taxing emotional demands, the slow pace, and the lack of external focus. Coaching can be less threatening to clients in less manic states because of its practical here and now focus. It may help clients manage their overactivity and may provide “reality-based,” practical guidelines on how to manage daily activities, goals, and the tendency to be impulsive and overcommitted. One analogy that may resonate for these individuals is to suggest that their “engine” goes from 0 to 100 miles an hour with little modulation. Understanding the drawbacks of euphoria and using cognitive-behavioral therapy to teach emotional-behavioral control can be useful (Scott, 2001). Relaxation training and daily physical exercise can be helpful in managing high levels of energy (Bruning & Frew, 1987).

Therapists who are relaxed, but who set limits, and who exhibit a sense of humor will work well with clients who experience wide mood swings: charming and likeable one minute but irritable and angry the next. These clients tend to be evasive, so feedback from others is useful if possible. Secondary paranoia is not unusual, so a misdiagnosis of schizophrenia is a danger.

Not all individuals with Scale 9 above a T-score of 65 are necessarily manic or even disorganized. The degree of disorganization and pathology is not always well correlated with elevations, so moderate scores on Scale 9 can predict hypomania. The interview and history determine the level of disturbance.

¹ Researchers have debated about using mindfulness for hyperactivity and distraction for some time.

There was a question about whether individuals with high levels of impulsive energy could actually engage in mindfulness meditation exercises. Zylowska et al. (2008) conducted an 8-week mindfulness training program for adults and adolescents with ADHD; subjects reported improvement in ADHD symptoms, and they also had better test performance on measures of attention and impulsivity.

² Dr. John Gartner, a clinical psychologist at Johns Hopkins Medical Center, contends that a certain combination of genes likely produces the undesirable disease of mania, while an even more common combination produces beneficial results of being hypomanic. He presents an interesting argument that individuals with hypomania actually have an edge in the world of business in his book titled *The Hypomanic Edge: The Link Between (A Little) Crazy and (A Lot of) Success in America* (2005).

³ Compliance therapy combines principles of motivational interviewing, inductive questioning, reflective

listening, and reinforcing adaptive behaviors and attitudes to explore client ambivalence and target medication adherence (Kemp, David, & Hayward, 1996).

⁴ In comparing meditation, stress management, and exercise all were found to have calming effects. Pulse rate, diastolic blood pressure, systolic blood pressure, and galvanic skin response were used as physiological stress indicators, and each of the strategies led to decreases in pulse rate and systolic blood pressure (Bruning & Frew, 1987).

⁵ It may help to educate clients about the relationship between hypomania and addictive behaviors. Hypomanic personality traits have been shown to predict manic episodes, substance abuse, and increased pleasure seeking and may be linked with hyperresponsiveness of the behavioral activation system (BAS). While this can lead to high achievement and goal directed behavior, it can also result in the more harmful consequences associated with mania and related clinical syndromes (Meyer, Rahman, & Sheperd, 2007).

⁶ The relaxation response describes the state of physiological reaction that is the direct opposite of the body's reaction under stress and overarousal (Benson, 1983) and can be achieved through various techniques such as progressive relaxation and meditation.

(Levak, Siegel, Nichols, & Stolberg, 2011)

THERAPEUTIC FEEDBACK LANGUAGE

Your profile shows that you are currently highly energetic. Your mind seems to be working unusually quickly, so you see connections between things and patterns and trends that others may not see. You may be so energized and euphoric that it is hard for you to sleep and get appropriate rest. You may feel that you have a special duty or mission in life because you see things so clearly, and you need to be a leader to help others see things as clearly as you do. Although socially skilled and charismatic, you may also show periods of intense irritability and anger, especially when people block you or get in your way when you're on a mission. You may use chemical agents as a way of trying to medicate your high, intense energy.

Your mind may work so quickly that it is hard for you to finish your sentences, and you may interrupt others without fully hearing them. You may move from topic to topic, almost as if you feel overwhelmed by all of life's possibilities. You may have grown up in an environment where you felt pressured to achieve and succeed. Perhaps recently some event occurred that made you feel a need to work harder to protect yourself against failure. Or there may have been a perceived setback or loss that precipitated a period of extremely high energy, which at times may leave you overwhelmed and unable to finish all the projects that you have undertaken. Work with your therapist to understand the pressure you feel to do great things. You may need some medication to help you make better use of your energy so that it doesn't flood your mind. Avoid chemical agents at this time, as they may interfere with clear

thinking. Start a daily exercise program to blow off steam and make sure that you are getting enough sleep and rest. Work with your therapist to make a list of the things that you have accomplished successfully, so that you can set more realistic goals for yourself and also be realistic about your past successes.

Feedback Statements—Elevated Profiles (T-Score > 65)

Strengths

Your profile reveals you have a number of strengths. You are an energetic, driven, ambitious individual who is able to think and move quickly and get a lot done. You generally are seen as positive, optimistic, and sunny. You have boundless energy, and you are able to see the connections between things so you think quickly. People with your profile often are highly social, engaging, and interesting.

Overcommitted or High Energy

Some of your strengths may actually work against you at times. You may have periods where you're so optimistic that you overcommit and take on so many tasks and activities that it is impossible to complete them all. Sometimes your energy may be so high that you have a reduced need for sleep and you feel impatient and angry with a world that moves too slowly. During these periods your moods may quickly shift from positive to negative: you may be upbeat and cheerful one moment and in the next angry and irritated, feeling that people are blocking you from getting what you want.

Euphoric or Unrealistic

Sometimes your optimism may shade toward euphoria. During these times, you may feel that you can accomplish anything and may engage in behavior that later is seen as reckless, even dangerous. You may come up with grand ideas that later prove to have been unrealistic.

Irritable, Explosive, Aggressive

You may feel so much energy that you can become irritated with people for not keeping up with you. When your energy is high, working on a single task can be difficult. You have a tendency to see the connections between things, so it's easy for you to become distracted and sidetracked. At other times, you may become so focused on a particular idea or activity that you keep at it when others feel you should let it go. At these times, when people try to persuade you that you are being unrealistic you can become quite angry, even explosive and aggressive.

Adventurous, Excitement Seeking, Hypomanic

People with your profile tend to need excitement, adventure, and a challenge, and without such stimulation you can become easily bored. You tend to go for the big, grand idea rather than taking a slow, steady approach toward solving a problem. Daily routine and details can be difficult for you. Your high level of energy is called hypomania, even mania, and though this may have been productive in the past your judgment may be currently impaired and could get you into trouble.

Possible Delusions or Hallucinations

During times of stress, you may get so wound up and your mind may work so quickly that you actually distort reality. In rare cases, people with your profile can experience reality distortions, reflecting your intense energy and internal pressure.

Possible Substance Abuse

People with your profile often use alcohol or some other chemical agent. You may feel that alcohol is not affecting you, so you keep drinking until you become quite inebriated or even black out. You may be trying to self-medicate your moods; however, this can be quite dangerous and may actually increase your mood instability.

Lifestyle and Background Feedback

People with your profile were often energetic, driven, and rambunctious children. Perhaps you've always been adventurous, excitement seeking, and risk taking. Sometimes, as children people with your profile were diagnosed with attention deficit hyperactivity disorder (ADHD). Your need for novelty and stimulation might have led to struggles with your parents over being controlled. In some cases, your need to do extremely well came from a childhood where you felt you had to achieve high levels of success to prove that you or your family was worthwhile. Now, you strive to excel through overcommitment, overactivity, and achievement. You may have recently experienced a setback or loss that makes you feel you have failed and will never be successful enough. This might have pushed you into an increased level of activity, driving you to accomplish great things in a short period of time.

Normal-Range Feedback (T-Score 50 to 65)

Your profile is in the average range. It suggests that you are energetic and optimistic. People generally see you as cheerful, positive, driven, and happy. You have strong needs to prove yourself, and you are motivated to achieve. You tend to be a big-picture thinker, and you can easily become distracted, bored, or restless. You can become irritable and angry, perhaps even explosive, when people get in your way, frustrate you, or block your goals. People with your profile tend to be somewhat distractible, and when you are excited about something, you can easily

become overcommitted and unrealistic. Because your pace and energy are greater than average, you may expect others to keep up with you, you may feel that the world moves too slowly, or may become impatient with how long it takes others to do things. You like to handle a number of projects at the same time and sometimes will take on more than you can possibly finish on time. You prefer a life that is filled with projects and excitement. Routine may be boring to you, and you likely seek novelty and a little risk.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Low-Point 9's

Black found several characteristics for normal college women with their lowest score on scale 9. The acquaintances of these girls described them as quiet, seclusive, modest, conventional, and humble. They also omitted to a significant degree the terms sociable and lively, talkative and aggressive, self-confident and self-controlled, adventurous, affectionate, and frivolous. In their self-ratings, the low-point 9 women endorsed the terms goodtempered, narrow interests, and unpopular. More significantly, they omitted from their self-descriptions a long series of terms, mostly quite socially favorable and self-enhancing. Although they avoided such unflattering descriptions as show offs, self-distrusting, and suspicious, they also denied a number of more acceptable trends. They did not say they were lively, energetic, enterprising, or versatile. Nor did they endorse natural, popular, sociable, polished, practical, grateful, or self-denying. Neither did they describe themselves as laughterful, relaxed, talkative, aggressive, adventurous, or having wide interests. Drake has observed in college counseling cases that low 9 seems to function as an inhibitor scale and that the low 9 counselees tend to be rather phlegmatic, with their behavior traits not well defined.

Sutton (1952) sought to find psychological uniformities running through the records of low-point 9 women who had been seen in the psychiatric service of the University of Minnesota Hospitals. After using a modified cluster search method (see the discussion in Volume II), she identified a modal profile that comprised the basic MMPI features of 101 females with lowpoint 9 records. Using this modal profile, she then selected a criterion group of eighteen women whose MMPI scores were very close to this standard. This select group had a mean profile with the total code 2° 371" 846/ 59 FKL?. In their presenting complaints, background history, and prognosis it was not possible to differentiate this group from a general run of female psychiatric inpatients. These women were depressed, severely neurotic and upset, tense and anxious. Although the potentiality of suicide is frequently noted in cases with profiles like this, the women with low points on scale 9 showed a marked reduction in rated suicidal risk. Although the group as a whole could not be differentiated from general female psychiatric inpatients, Sutton did find some significant differences between subgroups of women with this classic profile, separated on the basis of the height of the elevation of scale 9. The women with the lowest scores on scale 9 were judged to be either mixed psychoneurotic or reactive depressive in

their psychiatric illness, while the women with higher scores on scale 9 were diagnosed as involuntional melancholic to a significantly greater degree. Although both of these groups showed considerable improvement in the hospital, sometimes improving to a remarkable extent, the women with the lowest scores on scale 9 showed a better prognosis than those with high scores, both for recovery from the immediate upset and for long-range adjustment after returning to their families. Pearson (1950) also noted the favorable prognostic implications of low 9 scores in cases with involuntional melancholia.

Relations with Other Scales

91/19 Codes

See 19/91 Codes.

Guthrie reported that patients seen by a physician in general practice who presented this code type were all in acute distress. The symptoms revolved about the gastrointestinal tract, with symptoms in the upper levels predominating, although spastic bowel was noteworthy too. Archibald (1955) also found this pattern frequent in men with headache syndromes. Guthrie said that the patients with this pattern were seldom in a hypomanic state, but they were tense, restless, and ambitious. When seen by the physician they were frustrated by failure to reach their high levels of aspiration. It was quite easy to demonstrate the relationship between their hypochondriacal problems and the situational difficulties they faced, but these patients were reluctant to accept psychogenic formulations of their symptoms.

(Dahlstrom, Welsh, & Dahlstrom, 1979)

Medical patients with the 9-1 combination who were seen by a physician were all in acute distress. They seldom were hypomaniac; but they were tense, restless, and ambitious. They were frustrated by their failure to reach their high levels of aspiration. Physical complaints for men centered around the gastrointestinal tract and headaches (Guthrie, 1949).

92/29 Codes

See 29/92 Codes.

See also the 29 s above. Although an apparent psychological contradiction in the traditional interpretation of manic and depressive conditions as opposing ends of a single personality process, this combination occurs with some frequency in psychiatric practice. The combination usually appears at a time when the manic mechanisms are no

longer effective either in keeping the environmental pressures from overwhelming the patient or in distracting him from his mounting depression. The pattern reflects serious illness especially when scale 9 exceeds the primed level. Hathaway and Meehl (1951b) also noted the occurrence of this pattern in patients with organic deterioration of the brain.

(Dahlstrom, Welsh, & Dahlstrom, 1979)

1. The 9-2 combination tends to typify people for whom activity is no longer effective in warding off their depression. These people may be seen as agitated depressives (Dahlstrom et al., 1972).
2. Activity may alternate with fatigue (Caldwell, 1972).
3. These people may set it up so they will fail when they feel they cannot succeed (Caldwell, 1972).

93/39 Codes

See 39/93 Codes.

See also the 39s above. The normal college women with this code studied by Black were described in generally unflattering terms by their acquaintances. While the judges said these girls were sophisticated, they also labeled them dishonest, boastful, arrogant, show-offs, self-centered, suspicious, and flattering. These raters also omitted to a significant degree such terms as honest, loyal, natural, and popular. They did not describe the 93 girls as moody, partial, or having wide interests.

In the long list of adjectives checked by these girls in their self-ratings, it is not possible to find any more self-critical terms than flattering and aggressive. They did not seem to sense the reaction they evoked in others, for they described themselves as popular, sociable, loyal, generous, and grateful. Although they said they were polished and poised (matching perhaps the sophisticated rating their peers gave), they also said they were affectionate, good-tempered, and reasonable, with wide interests. They described themselves as enterprising and energetic, courageous and adventurous, cheerful and laughterful, alert and lively, and self-confident. In some contrast to the terms indicative of high energy level and easy involvement in various activities, these girls also described themselves as peaceable, orderly, and contented, and significantly omitted such terms as moody and easily bored. They included the terms adaptable and practical, while leaving out such adjectives as dreamy and unrealistic.

(Dahlstrom, Welsh, & Dahlstrom, 1979)

94/49 Codes

See 49/94 Codes.

See also the 49 s above. Guthrie noted that this group when seen by an internist did not present a homogeneous complaint picture, but rather showed general effects of tension and fatigue. These medical difficulties frequently followed quite clearly upon overactive and frankly hypomanic periods. The 94s showed poor family adjustment and had problems centering around their sexual adjustment. They did not stay in treatment long and therefore could be treated only superficially.

(Dahlstrom, Welsh, & Dahlstrom, 1979)

1. People with this combination may use acting out as a defense mechanism (Tromboli & Kilgore, 1983).
2. Patients seen by a physician with the 9-4 pattern showed the general effects of tension and fatigue. These effects followed periods of great overactivity (Guthrie, 1949).
 - a. These patients showed poor family adjustment and had problems centering around their sexual adjustments.
 - b. They did not stay in treatment long; therefore, they could only be treated superficially.
3. The 9-4 combination is the most common one found in entering college freshmen (9 percent of the men's profiles and 8 percent of the women's) (Fowler & Coyle, 1969).

95/59 Codes

See 59/95 Codes.

96/69 Codes

See 69/96 Codes.

See the 96 code type in the Marks and Seeman Atlas (the defining characteristics of this pattern are provided in Chapter 3).

ADULT CODE: 9-6/6-9*

Diagnosis

Psychosis 85%	Schizophrenic/paranoid
Psychoneurosis 10%	Mixed

Personality disorder 5%

Sociopathic

Brain syndrome 0%

Personality Description

Thought disorders are characteristic of patients yielding this profile. They subjectively report difficulty concentrating and difficulty thinking. They are ruminative, overrideational, and obsessional. What they say is frequently irrelevant or incoherent. The stream of thought is retarded. These patients tend to be disoriented and appear perplexed; often they are delusional and hallucinatory. Clinicians judge them to spend a good deal of time in personal fantasy and in daydreaming and report regression as one of their principle mechanisms of defense.

Patients with this profile are also described by clinicians as tense, high-strung, and jumpy; they are nervous, they tremble and sweat, and show various other signs of anxiety. They are sometimes tearful and cry openly. Because they are overanxious, they tend to make emergency responses to any perceived threat and to overreact to minor matters. They are impulsive, unpredictable, changeable, and restless, as well as vulnerable to real or imagined threat. They tend to be uncooperative and yet they are readily dominated by others— possibly because of their exaggerated needs for affection. Typically, they exhibit poor judgment and their approach to problems is stereotyped and unoriginal. Ten percent are seen as homicidal. In summary, they are unable to express their emotions in any modulated or adaptive way.

This profile is also indicative of paranoid features. Indeed, 9-6 patients are hostile, irritable, and moody; they are given to having grandiose thoughts and ideas of reference. Twenty-five per cent describe themselves as excessively religious. They are generally distrustful and constantly question the motivations of others. Projection is often employed as their major defense. These patients are afraid of emotional involvement of any sort. They are also conflicted over sexual matters; their heterosexual adjustment is described by clinicians as poor. They judge themselves and others in terms of popularity, and although they are somewhat ambitious and would like to get ahead, their prevailing mistrust of people leads them to keep others at a distance and prevents them from establishing close and meaningful relationships. The parents of patients who present this profile were not consistent in their disciplinary actions. The fathers tended to be permissive while the mothers were strict. Fathers were also viewed as indifferent, rejecting, or even neglecting; mothers were described as affectionate and overprotective. Fewer than half of these parents were seen as affectionate by the 9-6 patients. People with this profile are generally inpatients who have been diagnosed as psychotic (85%). The presenting disorder seems to permeate nearly all areas of the patient's life, but those most frequently affected are home, occupation, and social relations. These patients are quite young (mean age 26 years) at the onset of the disorder, and have often had previous episodes of one sort or another. Unfortunately, the prognosis for these patients is considered poor.

Marks et al. (1974) found the 94/6-9 pattern in a university hospital and outpatient clinic. The profile primarily was found for females who were agitated, tense, excitable, suspicious, and hostile. The Marks, Seeman, and Haller hook should be consulted for further information concerning this profile.

Rules

9 and 6 above 70 Ts

1, 2, and 3 below 70 Ts

6 greater than 4 (or 4 minus 6 less than 5 T-scores)

9 minus 2 more than 15 T-scores

9 minus 4 more than 5 T-scores

9 minus 8 more than 10 T-scores

0 below 70 Ts

L and K below 70 Ts, F below 80 Ts

Most Descriptive

57. Seems unable to express own emotions in any modulated adaptive way (8.6) +

104. Delusional thinking is present (8.6) +

8. Overreacts to danger or makes emergency responses in the absence of danger (8.4) + +

32. Is tense, high-strung, and jumpy (8.4) ++

96. Genotype has paranoid features (8.4) +

87. Is afraid of emotional involvement with others (8.0) +

85. Has inner conflicts about sexuality (7.8) +

103. Reports difficulty in thinking; can't concentrate (7.8) +

16. Is overanxious about minor matters and reacts to them as if they were emergencies (7.6) +

65. Has an exaggerated need for affection (7.6) +

68. Keeps people at a distance; avoids close interpersonal relationships (7.6)

93. Exhibits depression (manifest sad mood) (7.6)

17. Utilizes projection as a defense mechanism (7.4)

44. Is distrustful of people in general; questions their motivations (7.4)

46. Is nervous; tense in manner; trembles, sweats, or shows other signs of anxiety (7.4) +

58. Tends to be ruminative and overideational (7.4)

77. Is tearful and/or cries openly (7.4) +
78. Is irritable (7.2)
100. Obsessive thinking is present (7.2)
1. Is vulnerable to real or fancied threat; generally fearful; is a worrier (7.0)

Least Descriptive

11. Is cheerful (1.0)
107. Would be organized and adaptive when under stress or trauma (1.0) —
63. Has a resilient ego-defense system; has a safe margin of integration (1.2)
37. Defenses are fairly adequate in relieving psychological distress (1.4) —
42. Is "normal", healthy, symptom free (1.8)
49. Appears to be poised, self-assured, socially at ease (2.0)
59. Is socially extroverted (outgoing) (2.0)
4. Has a need to think of self as an unusually self-sufficient person (2.2) —
25. Presents a favorable prognosis (2.4)
64. Expresses impulses by verbal acting out (2.4)
30. Has "diagnostic" insight; awareness of the descriptive features of own behavior (2.6)
51. Exhibits good heterosexual adjustment (2.6)
67. Is able to sense other person's feelings; is an intuitive, empathic person (2.6)
61. Tends to be flippant both in word and gesture (2.8)
69. Gets along well in the world as it is; is socially appropriate in own behavior (2.8) —
89. Is provocative (2.8)
83. Is argumentative (3.0)
84. Is critical; not easily impressed; skeptical (3.0) —
108. Has the capacity for forming close interpersonal relationships (3.0)

Areas of Manifestation

Length of Onset

Personality 95.0	Less than a week 25.0+
Home 55+	A week to a month 30.0+
Social 45.0+	A month to a year 25.0-
Occupational 30.0+	Over a year 20.0-
Marital 25.0	

Sexual 10.0

Educational 5.0

Religious 0.0

Duration of Illness

Less than a week 0.0

A week to a month 25.0+

A month to a year 30.0

Over a year 45.0

System Involvement

Gastrointestinal 30.0

Genitourinary 15.0

Musculoskeletal 15.0-

Cardiorespiratory 0.0-

Previous Episodes

None 30.0-

Similar 30.0

Other 40.0+++

Age of Onset

Mean age (years) 26.1

Range 16:35

97/79 Codes

See 79/97 Codes.

98/89 Codes

See 89/98 Codes.

98's

Black studied the ratings of normal college women with this code and found them described in somewhat unflattering terms both by their peers and by themselves. Other girls saw these women as thoughtful, idealistic, and persevering, but also described them as self-centered and infantile, boastful and fickle, unemotional and self-dissatisfied. They omitted to a significant degree such terms as high-strung and courageous. In their self-descriptions, the 98 women said they were polished, relaxed, and thoughtful. They omitted the terms sensitive, dependent, selfish, and worrying. They also described themselves as secretive, eccentric, gloomy, and inarticulate. Although they said that they were courageous, they omitted such terms as frank, reasonable, and clear-thinking. They also omitted the description likes drinking. Hathaway and Meehl (1951b) indicated that the 98 combination was usually restricted in their samples to the psychiatric population and that it implies a more malignant hypomanic picture than the 94 combination. Guthrie also found this to be the case in his group of medical patients. His patients

gave histories of having periods of hyperactivity and then seeking medical help as their depressions came on. Their behavior showed some variation, but schizoid features were not prominent. Guthrie also noted that the F-scale elevation varied with the severity of their condition. Data on this pattern also appear in the 89-98 pattern in the Marks and Seeman Atlas (see Chapter 3 for the defining characteristics of this pattern).

(Dahlstrom, Welsh, & Dahlstrom, 1979)

- 1) The 9-8 pattern is more likely found in mental hospital populations than in non-hospitalized populations. It indicates more serious problems than the 9-4 combination (Dahlstrom et al., 1972). The F scale elevation tends to vary with the severity of these people's condition. The higher the F scale with the 9-8 pattern the more serious the condition tends to be.
- 2) Marks et al. (1974) found the 8-9/9-8 pattern in a university hospital and outpatient clinic. The pattern occurred mostly with women characterized by delusional thinking, ruminations, anxiety, and agitation. The Marks, Seeman, and Haller book should be consulted for further information concerning this profile.

90/09 Codes

This codetype is uncommon. A hypomanic, driven individual generally is not also shy, socially withdrawn, and socially insecure. However, this codetype does occur and describes an individual who is emotionally self-sufficient and cynical, with a tendency to obsess, ruminate, and manipulate others to get their needs met. These individuals can exhibit hypomanic traits, are readily bored, and have difficulty with attention and concentration. These individuals tend not to be depressed although they may complain of dysphoria. They are shy and withdrawn, but can be quietly egocentric and competitive. They are self-sufficient, self-directed people who can become more garrulous and talkative once they are comfortable in a small social group. In such situations they can be quite demanding of attention and extol their own virtues. People may see these individuals as somewhat aloof and disdainful toward others. This may reflect the high 9 individual's self-confidence and grandiosity. It can be helpful to initially ignore the elevated Scale 0 and to interpret the two-point codetype without the Scale 0.

(Dahlstrom, Welsh, & Dahlstrom, 1979)

- Anxiety, tension, dysphoria, and inertia, with emotional and behavioral undercontrol, hostility, impulsiveness, fears of domination, alienation, and social discomfort. Check third highest scale.

- In college counselees, when the 9-0 pattern occurred the behavior shown by the 0 scale seemed to dominate in that the people were socially shy and withdrawn even though agitated (Drake & Oetting, 1959).

Description:

Adequate social skills, high energy, self-confident, present as happy and well-adjusted, may be grandiose and a bit manic

TREATMENT

See treatment section under the Spike 9 codes. Social skill building may also be useful.

THERAPEUTIC FEEDBACK LANGUAGE

See Scale 9 and Scale 0 feedback.

Spike 0 (Si)

Scale 0: Social Introversion (Si)

Descriptors (T-Scores > 65)

Complaints

social apprehension, shyness, self-consciousness, possible social phobia, fears of public speaking, feeling alienated from others, social avoidance, difficulties with physical affection, difficulties expressing intimate feelings, low self-confidence

Thoughts

prone to worry, self-doubting, self-deprecating, defensively critical or judgmental of others

Emotions

social anxiety, "stage fright," easily embarrassed, feels inferior, difficulty expressing emotion or affection

Traits and Behaviors

shy, introverted, self-conscious, easily embarrassed, awkward, lacking emotional spontaneity, difficulty expressing emotions, especially warmth and affection, overwhelmed by too much attention, irritable when embarrassed, avoids groups or crowds, prefers of small intimate friends rather than large groups of unknown people

(Levak, Siegel, Nichols, & Stolberg, 2011)

High scores ($T \geq 65$) and the Spike 0 codetype reflects a preference for being alone rather than with others, particularly if no other scale is elevated above T -65. Elevations on Scale 0 above T -65 suggest a person who is shy, interpersonally uncomfortable, insecure, introverted, and submissive. As the score approaches T -75, this scale also suggests an absence of social supports, perhaps even a schizoid aloofness, and problems in establishing meaningful attachments with others.

Moderately high scores (T -55–65) may indicate a personality trait of being self-contained, autonomous, and quite adaptive in situations (e.g. college) requiring sustained periods of solitary activities. Elevations of Scale 0 tend to

reduce the likelihood of acting out indicated by other scale elevations (e.g. Scales 4 and 9), but may exacerbate the rumination or self-absorption indicated by, for example, Scales 2, 7, or 8.

Moderately low to very low scores ($T < 45$) are obtained by persons who prefer to be with others and feel anxious when alone. Most often they are outgoing, gregarious, friendly, enthusiastic, and have strong needs for affiliation, social recognition, and status. When scores are below $T=35$, their strong social presence may threaten others who may then judge them as opportunistic, manipulative, shallow, superficial, and flighty. Usually Spike 0 persons do not seek treatment for their shyness unless they are forced by circumstances to be in situations that do not allow them personal space. If shyness is a problem, social skill building, self-esteem building, and relaxation training therapies are most useful.

Therapist Notes

In the average ranges, these individuals are mildly shy and can sometimes feel self-conscious and be at a loss for words. They are apt to be quite reliable and dependable, especially if no other clinical scales are elevated. They are independent and self-reliant. While elevation on Scale 0 measures shyness, self-consciousness, and discomfort with large groups, it also suggests difficulty being spontaneous, playful, and emotionally open with people. The items of Scale 0 include social withdrawal and dysphoria, with a tendency to brood and to be easily hurt by criticism. At higher elevations, social passivity, difficulties with self-assertion, and trouble with being reasonably demanding reflect the unsatisfying aspects of severe introversion. Research from twin studies suggests that introversion and extroversion are normally distributed, highly heritable traits (Scarr, 1969), and other studies suggest that this characteristic tends to be stable over time (Costa & McCrae, 1992). People who were shy and socially uncomfortable as children tend to remain so as adults. Similarly, the extroverted, socially active child or adolescent who may have had trouble at school studying because of the need to socialize often becomes the extremely socially engaged adult. We hypothesize that T-scores above 65 suggest individuals with a genetic predisposition to shyness who have become socially anxious and have reduced or abandoned their need for emotional connection and physical touch from others. T-scores below 40 suggest a drive toward social interaction, sometimes, but not always, out of insecurity. Extreme low scores may reflect not only an insatiable need to be in the spotlight but also a low level of socially acceptable embarrassment in the face of obvious self-serving and self-aggrandizing behavior. (Levak, Siegel, Nichols, & Stolberg, 2011)

Lifestyle and Family background

When T-scores are above 65, childhoods in which shyness was experienced as painful and isolating are likely. While healthy, psychologically well-adjusted, but mildly shy individuals could have had positive experiences gravitating toward like-minded, socially introverted peers, individuals with higher elevations on Scale 0 may have experienced humiliation, embarrassment, and social awkwardness. This may have been exacerbated by personal eccentricities or shame about family of origin. For example, an Asian American client who reported being shy in childhood was embarrassed about his family's cultural identity and tendency to speak only in their native language. He was embarrassed to bring home friends, and his shyness was aggravated by his cultural separateness. In another case, an extroverted individual with a low T-score on Scale 0 reported growing up in a strict religious family where it was prohibited for her to interact with peers who were not involved in the church. As a teenager, she rebelled against her parents' restrictions and she was focused on socializing to the exclusion of her studies. While introversion and extroversion are not in themselves pathological or disruptive of happiness, conditioning experiences can accentuate the less adaptive aspects of both ends of the shyness continuum.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Scale 0 was not included in early code frequency tabulations sufficiently often to enable workers to gain either an appreciation of its occurrence in various populations or substantial empirical data on its important personality correlates. The tabulations provided in Appendix M are not sufficient to establish very many trends. Hathaway and Monachesi (1963; see Tables 5 and 6 in Appendix M) found it was at about the middle rank for ninth-grade boys and girls, occurring most frequently in combination with scales 7 and 8. Panton (1959; see Tables 17 and 18 in Appendix M) found scale near the bottom rank in frequency of high points on records from male and female prison inmates. Goulding (1951) reported that scale was the most frequent low point in codes from male college students. Welsh and Andersen (1948) found that for male psychiatric and neurological patients in a Veterans Administration hospital scale was the high point in less than 3 percent of the cases while it was the low point in more than one-third of the profiles. As a high point, scale was most frequently paired with scales 2, 7, and 8. Scale peaks when they did occur were associated with diagnoses of some form of psychoneurosis. The most extensive report of the relationship of scale peaks to various personality features comes from the originator of the scale, Lewis E. Drake. Most of these observations have been summarized in An MMPI Codebook for Counselors prepared in collaboration with E. R. Oetting (1959). Only a few of the patterns summarized there have been abstracted here and the interested reader is urged to consult the full report for many additional configurations.

Modifying Scales

- When Shyness/Self-Consciousness (Si1) and Shyness (SOD2) are elevated, clients feel socially awkward and easily embarrassed. They are likely to have trouble being assertive.
- When Social Avoidance (Si2) and Introversion (SOD1) are elevated, look for social, behavioral avoidance. These individuals tend to remain on the outskirts of any group and to look for “escape routes” when forced to attend parties or social events.
- When Self/Other Alienation (Si3) is elevated these clients feel alienated, inadequate, and self-conscious. High scorers may feel unattractive, unlikable, and vulnerable to judgment from others.
- Scale 2 elevations aggravate the self-consciousness and painful pre-occupation with “not being good enough.” Marks (personal communication, June 1990) has called the 2-0/0-2 profile the “wire mother” profile, suggesting the extinction of the normal human desire to be touched and held by others due to being raised by a “wire mother” (Harlow, 1962).
- When Scale 4 is elevated, individuals are sour, caustic, and uncommunicative. Anger would be expressed as sarcasm and quiet withholding. Manipulation would be subtle and rationalized by a cynical view of others.
- When Scale 7 is elevated, look for anxious, insecure, ruminative clients who dread being “called on” in social situations and may exhibit social phobia.
- When Social Alienation (Sc1) is elevated, this would aggravate the sense of emotional disconnection from others. If Social Alienation (Pd4) and Self-Alienation (Pd5) are elevated, shyness is aggravated by a sense of cynicism and distrust that others can be emotionally trusted.
- When Poignancy (Pa2) is elevated, the sensitivity and self-consciousness already associated with Scale 0 elevations is aggravated, and these clients take things personally and feel wounded by the insensitivity of others. Sometimes Ego Inflation (Ma4) is elevated; these clients are withdrawn but have a sense of superiority. They feel self-righteous about “not suffering fools.”

- When Depression (DEP) or Low Positive Emotion (RC2) are elevated, consider the possibility of a long-term characterologically depressed, pessimistic, and defensively sour individual.
- When Anger (ANG) is elevated, abrupt, angry reactions that appear to others as disconnected from precipitating circumstances are recurrent. Anger is sudden and brittle and may be exhibited when individuals feel cornered, criticized, exposed, or embarrassed.
- When Cynicism (CYN) is elevated, the clients' introversion is of a dis-trustful, cynical kind. They rationalize their withdrawal from others as necessary in a dog-eat-dog world in which people take care of their own interests.
- When Anxiety (ANX) is elevated, social phobias and panic, especially when called on to speak publicly, are prevalent.
- When Fears (FRS) is elevated in the absence of other scale elevations, preoccupation with specific fears and phobias relating to dealing with other people and social situations is suggested.
- When Bizarre Mentation (BIZ), Psychoticism (PSYC), or Aberrant Experiences (RC8) are elevated, severely damaged self-esteem and pre-occupations about being judged, criticized, or being seen as defective take on possibly psychotic proportions.

(Levak, Siegel, Nichols, & Stolberg, 2011)

Male

Low 1/9 Introverted or self-conscious or socially insecure.

Female

Low 1 Lacks skills with the opposite sex.

Low 3 Socially insecure.

Low 5 Socially shy, shy in the interview.

Low 9 Socially shy.

Nothing Low Socially shy, lacks skills with the opposite sex, nonverbal.

(Drake & Oetting, 1959)

Description:

Situational adjustment difficulties or schizoid adjustment or mild but chronic distress; they are shy and easily embarrassed, prone to phobias and fears

Therapy and Therapeutic Pitfalls

Therapy should focus on helping clients interact socially without undue fear or anxiety. Education about the genetic component of shyness and therapy to normalize their experience is useful. Assess the nature and severity of the shyness and whether general social anxiety is the issue or whether introversion is limited to certain specific situations (e.g., public speaking). Medication and cognitive-behavioral therapy (CBT) can be ameliorative of social phobia. Two types of CBT are particularly effective with social phobia: (1) skill building through education and role playing; and (2) small-group therapy (Barlow, Raffa, & Cohen, 2002). Typically, these clients do not seek treatment for shyness unless they find themselves in situations that demand acting in ways that are contrary to their genetic makeup. For example, highly introverted individuals who are forced to relate to others due to job or living situations may develop symptoms of stress. Conversely, highly extroverted clients (T-score <40) may experience stress if trapped in situations where they can't relate to many people.

High Scale 0 individuals experience difficulty with emotional openness and intimacy, so they work better with directive, coaching styles of psychotherapy. These clients tend to be compliant (unless Scale 4 or 9 is elevated); they do not resist authority, and they see the therapist as an expert. Being overly friendly and attempting to inspire a therapeutic alliance too quickly tends to backfire. Therapeutic interaction is apt to be somewhat anxiety provoking, so online assignments or at-home reading allows the assimilation of information without the interfering anxiety of the therapist-client relationship. Sometimes rehearsing simple social icebreakers can be helpful.

When Scale 0 is below 40, problems usually center on the mismatch of clients with their current situation. For example, a highly successful and extroverted salesman was promoted to a supervisory position where his interaction with others was curtailed. He began to drink heavily and socialize in the evenings at the expense of his marriage. Therapy revealed that, although promoted, he felt trapped and unhappy in a world where he had little social interaction. Therapy in such situations involves helping clients become aware of the source of their difficulty and then engaging in supportive concrete problem solving.

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you are a shy person comfortable with small groups of people you know well rather than large groups of new people. Sometimes when called upon in a social setting without being prepared, you may find yourself embarrassed or tongue-tied.

Shyness tends to be a genetic trait, and as long as you're comfortable being shy, it does not reflect any mental disturbance. Work with your therapist to find a group of like-minded people to discuss ways to deal with your shyness so that you do not feel awkward and embarrassed in new social situations. Sometimes reaching out to others by asking them questions about themselves can promote a conversation so that you do not have to be at a loss for words.

Feedback Statements—Elevated Profiles (t-scores > 65)

Strengths

You have a number of strengths. You are comfortable being alone, and you do not seem to need a great deal of affirmation, interaction, or approval from others. Therefore, you can work quietly on your own for long periods of time. You are an independent and self-reliant person who turns inward to find direction rather than seeking others' guidance, advice, or support.

Shy, Easily Embarrassed, Awkward

You also test as someone who is somewhat shy and uncomfortable with large groups of people whom you don't know. Being called on, having to speak in front of people without preparing, or suddenly being the focus of attention can be difficult for you. You can feel embarrassed, awkwardness, and uncomfortable if you get too much attention, especially if you are unprepared for it. You are someone who does not readily open up and share how you feel with others, and you may feel awkward when people are emotionally open with you. You are a private person, and you do not want people to invade your personal space or your sense of boundaries. Others may misperceive you as aloof, even indifferent or snobbish, because you don't let down your guard quickly unless you feel comfortable.

Self-Conscious or Social Anxiety

Meeting new people is difficult for you, especially if it is in a large group such as a party or social event. Sometimes when you meet new people, you may feel tongue-tied and uncomfortable. After the first few moments when people first meet you, you may find yourself lost for words, struggling to know what to say. Often, you may feel self-conscious, worrying that somehow you stand out like a sore thumb and that people are being critical or judgmental of you. When you feel stressed, it's easy for you to withdraw, to be by yourself so that you can "de-stress." When you are forced to go to social events, you may experience anxiety, and you are probably aware of an escape route—that is, how you can leave without drawing attention to yourself.

Normal-range Feedback (t-score 50 to 55)

Your profile is in the normal range, meaning that you are neither shy nor extroverted. You enjoy people in small groups where you can avoid small talk and get to know people. You can become "burned out" on too much socializing, and you tend to be reserved and somewhat uncomfortable with large groups of new people; around strangers you may feel self-conscious and at a loss for words. If you are in an unstructured situation with strangers, you are likely to be less comfortable than with people you know. You do not need many friends, but you do enjoy small groups of people you know well. People with your profile like to avoid aggressive confrontations with others.

Normal-range Feedback (t-score 55 to 65)

You are a mildly shy person who is uncomfortable meeting large groups of new people. You prefer the intimacy of small groups of people you know, and you find small talk difficult and tedious. You are likely comfortable being alone for periods of time, you do not need many people's approval, and you may not need a lot of emotional and physical validation. People who are intense and quick to become friendly may leave you feeling uncomfortable. At social events you may feel a need to have control over when you can leave because you become "burned out" by socializing.

(Levak, Siegel, Nichols, & Stolberg, 2011)

THERAPEUTIC FEEDBACK LANGUAGE FOR LOW SCORES

Feedback Statements (t-scores < 45)

Your profile suggests you have a number of strengths. You are an extroverted, people-oriented individual who is never happier than relating to others. You may find it easy to talk to people you've never met, perhaps engaging

people while standing in line. You may be curious about people when in new social situations and find it easy to talk to them. You may find yourself “antsy” and agitated when you are alone or when you are confined to small groups of people that you already know well. You may feel yourself excited and enthusiastic about going to parties and loud social events where there is a chance to meet new people. You’re not afraid to relate to people, and you’re not afraid to open up, talk about how you feel, and inquire about others’ feelings. You probably have many friends, and sometimes you may get socially overcommitted.

Lifestyle and Background Feedback (t-score < 45)

You enjoy being the center of attention, and you may actively seek it. You were probably always socially comfortable as a child and enjoyed being around people. You made friends easily, and if you had to move, new social situations were exciting and interesting. If parents tried to restrict your social life as a way of controlling your behavior, it would have made you very frustrated and angry. Perhaps as a teenager, you got in trouble for socializing when you should have been studying. Now you need a great deal of social interaction, and you become unhappy if you are not able to get it.

Feedback (T < 35)

Your profile suggests that you are an extraverted person who enjoys relating to others. You are comfortable meeting new people and even talking to people whom you’ve never met before. It is important for you to have time to be around people and you may become bored by spending too much time alone.

(Levak, Siegel, Nichols, & Stolberg, 2011)

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Relations with Other Scales

01/10 Codes

See 10/01 Codes.

Male

Low 9 Introverted or self-conscious or socially insecure.

Female

Low 3 Socially insecure.

Low 5 Socially shy, shy in the interview, headaches.

Low 9 Socially shy.

Nothing Low Socially shy, lacks skills with the opposite sex, nonverbal.

(Drake & Oetting, 1959)

012 Code

Male

Low 3/4/5/6/7/8/9 Introverted or self-conscious or socially insecure, lacks social skills.

Nothing Low Introverted or self-conscious or socially insecure, lacks social skills, lacks skills with the opposite sex, unhappy, worries a great deal, insomnia.

Female

Low 3 Socially shy, lacks skills with the opposite sex, socially insecure, lacks self-confidence.

Low 4 Socially shy, lacks skills with the opposite sex, lacks self-confidence.

Low 5 Socially shy, lacks skills with the opposite sex, shy in the interview, socially insecure, lacks self-confidence, indecisive, depressed, anxieties, nervous, headaches, tense on examinations, wants answers.

Low 6 Socially shy, lacks skills with the opposite sex, socially insecure, lacks self-confidence, nonverbal.

Low 7/8 Socially shy, lacks skills with the opposite sex, lacks self-confidence.

Low 9 Socially shy, lacks skills with the opposite sex, lacks self-confidence, mother conflict.

Nothing Low Socially shy, lacks skills with the opposite sex, lacks self-confidence, nonverbal, depressed.

(Drake & Oetting, 1959)

013 Code

Male

Low 9 Introverted or self-conscious or socially insecure.

Female

Low 2 Socially extroverted (3-2).

Low 5 Socially shy, shy in the interview, insomnia, exhaustion, headaches, home conflict, distractible in study.

Low 9 Socially shy.

Nothing Low Socially shy, lacks skills with the opposite sex, father conflict, mother conflict, tense on examinations, verbal (3-X), nonverbal (0-X).

(Drake & Oetting, 1959)

014 Code

Male

Low 9 Introverted or self-conscious or socially insecure.

Female

Low 2 Father conflict (04), socially extroverted (4-2).

- Note: Scale 2 coded low was infrequently associated with father conflict.

Low 3 Socially insecure (0-3), father conflict.

- Note: Scale 4 coded high was infrequently associated with social insecurity.

Low 5 Socially shy, lacks skills with the opposite sex, shy in the interview (0-5) father conflict, rebellious toward home, anxieties, headaches, indecisive.

- Note: Scale 4 coded high was infrequently associated with shyness in the interview.

Low 6 Father conflict, vague goals, lacks academic drive.

Low 7/8 Father conflict.

Low 9 Father conflict, socially shy.

Nothing Low Father conflict, socially shy, lacks skills with the opposite sex, nonverbal.

(Drake & Oetting, 1959)

015 Code

Male

Low 2/3 Introverted or self-conscious or socially insecure, shy in the interview, home dependency.

Low 4 Introverted or self-conscious or socially insecure, shy in the interview, home dependency, home conflict.

Low 6/7/8/9 Introverted or self-conscious or socially insecure, shy in the interview, home dependency.

Nothing Low Introverted or self-conscious or socially insecure, shy in the interview, home dependency, home conflict, insomnia.

Female

Low 3 Socially insecure.

Low 9 Socially shy (0-9).

- Note: Scale 5 coded high was infrequently associated with social shyness.

Nothing Low Socially shy (0-X), lacks skills with the opposite sex, nonverbal, distractible in study.

- Note: Scale 5 coded high was infrequently associated with social shyness.

(Drake & Oetting, 1959)

016 Code

Male

Low 9 Introverted or self-conscious or socially insecure.

Female

Low 2 Socially shy (06), socially extroverted (6-2), physical inferiority.

Low 3 Socially shy, socially insecure, physical inferiority.

Low 4 Socially shy, shy in the interview, physical inferiority.

Low 5 Socially shy, shy in the interview, physical inferiority, headaches.

Low 7/8/9 Socially shy, physical inferiority.

Nothing Low Socially shy, lacks skills with the opposite sex, physical inferiority, nonverbal, 8+ conferences, restless.

(Drake & Oetting, 1959)

017 Code

Male

Low 2/3/4/5/6/8/9 Introverted or self-conscious or socially insecure, shy in the interview, mother conflict, indecisive, unhappy (07)

Nothing Low Introverted or self-conscious or socially insecure, shy in the interview, lacks skills with the opposite sex, mother conflict, sibling conflict, nonresponsive or nonverbal, tense, indecisive, unhappy, worries a great deal, insomnia, confused.

Female

Low 2 Socially shy (07), socially insecure (07), lacks self-confidence (07).

- Note: Scale 2 coded low was infrequently associated with social shyness, social insecurity, lack of self-confidence.

Low 3 Socially shy, socially insecure, lacks self-confidence, cried in the interview.

Low 4 Socially shy, socially insecure, lacks self-confidence.

Low 5 Socially shy, socially insecure, shy in the interview, lacks self-confidence, indecisive, anxieties, nervous, exhaustion, insomnia, headaches.

Low 6/8/9 Socially shy, socially insecure, lacks self-confidence.

Nothing Low Socially shy, socially insecure, lacks skills with the opposite sex, lacks self-confidence, sibling conflict, nonverbal, headaches.

(Drake & Oetting, 1959)

018 Code

Male

Low 9 Introverted or self-conscious or socially insecure.

Nothing Low Indecisive, unhappy, worries a great deal, insomnia, confused.

Female

Low 2 Socially shy (08), shy in the interview, nonverbal, nervous.

- Note: Scale 2 coded low was infrequently associated with social shyness.

Low 3 Socially shy, shy in the interview, socially insecure, nonverbal, nervous.

Low 4 Socially shy, shy in the interview, nonverbal, nervous.

Low 5 Socially shy, shy in the interview, nonverbal, nervous, anxieties, headaches, distractible in study.

Low 6/7/9 Socially shy, shy in the interview, nonverbal, nervous.

Nothing Low Socially shy, shy in the interview, lacks skills with the opposite sex, nonverbal, 8+ conferences, nervous, depressed, mother conflict, father conflict, sibling conflict.

(Drake & Oetting, 1959)

019 Code

Male

Low 6 Rationalizes a great deal

Female

Low 2 Socially shy (09), socially extroverted (9-2).

- Note: Scale 2 coded low was infrequently associated with social shyness.

Low 3 Socially shy, socially insecure, vague goals.

Low 4 Socially shy, shy in the interview (9-4), nonresponsive.

- Note: Scale 9 coded high was infrequently associated with shyness in the interview.

Low 5 Socially shy, shy in the interview (0-5), verbal, exhaustion, headaches.

- Note: Scale 9 coded high was infrequently associated with shyness in the interview.

Low 6/7/8 Socially shy.

Nothing Low Socially shy, lacks skills with the opposite sex, nonverbal.

(Drake & Oetting, 1959)

02/20 Codes

See 20/02 Codes.

Drake and Oetting report that several manifestations of social withdrawal and insecurity are frequent in the case records of men with this profile who sought help in a college counseling center. They appeared unhappy and tense, worried a great deal, and complained of insomnia. They were introverted and socially insecure, and lacked effective social skills, particularly with members of the opposite sex. Women in their study showed essentially the same presenting picture, with additional evidence of depression, lack of self-confidence, and (when scale 1 was the low point) feelings of physical inferiority.

(Dahlstrom, Welsh, & Dahlstrom, 1979)

- 1) In college counselees, men with a 0-2 combination typically appear unhappy and tense, worry a great deal, and lack effective social skills, particularly with members of the opposite sex (Drake & Oetting, 1959).
- 2) College women also show the same presenting picture as college men, with the addition of depression, lack of self-confidence, and (when scale 1 is the low point) feelings of physical inferiority (Drake & Oetting, 1959).

Male

Low 1/3/4/5/6/7/8/9/ Introverted or self-conscious or socially insecure, lacks social skills.

Nothing Low Introverted or self-conscious or socially insecure, lacks social skills, lacks skills with the opposite sex, tense, unhappy, worries a great deal, insomnia.

Female

Low 1 Socially shy, lacks skills with the opposite sex, lacks self-confidence, physical inferiority.

Low 3 Socially shy, lacks skills with the opposite sex, socially insecure, lacks self-confidence.

Low 4 Socially shy, lacks skills with the opposite sex, lacks self-confidence.

Low 5 Socially shy, lacks skills with the opposite sex, shy in the interview, socially insecure, depressed, anxieties, nervous, wants answers, lacks self-confidence, indecisive, tense on examinations.

Low 6 Socially shy, lacks skills with the opposite sex, socially insecure, lacks self-confidence, nonverbal.

Low 7/8 Socially shy, lacks skills with the opposite sex, lacks self-confidence.

Low 9 Socially shy, lacks skills with the opposite sex, lacks self-confidence, mother conflict.

Nothing Low Socially shy, lacks skills with the opposite sex, lacks self-confidence, nonverbal, depressed.

(Drake & Oetting, 1959)

023 Code

Male

Low 1/4/5/6/7/8/9 Introverted or self-conscious or socially insecure, lacks social skills.

Nothing Low Introverted or self-conscious or socially insecure, lacks social skills, lacks skills with the opposite sex, tense, unhappy, worries a great deal, insomnia

Female

Low 1 Socially shy, lacks skills with the opposite sex, lacks self-confidence, physical inferiority.

Low 4 Socially shy, lacks skills with the opposite sex, lacks self-confidence.

Low 5 Socially shy, lacks skills with the opposite sex, shy in the interview, socially insecure, lacks self-confidence, indecisive, depressed, exhaustion, nervous, anxious, insomnia, headaches, tense on examinations, distractible in study, home conflict, wants answers.

Low 6 Socially shy, lacks skills with the opposite sex, socially insecure, lacks self-confidence, nonverbal.

Low 7/8 Socially shy, lacks skills with the opposite sex, lacks self-confidence.

Low 9 Socially shy, lacks skills with the opposite sex, lacks self-confidence, mother conflict.

Nothing Low Socially shy, lacks skills with the opposite sex, lacks self-confidence, mother conflict, father conflict, tense on examinations, nonverbal (0-X) verbal (3-X), depressed.

(Drake & Oetting, 1959)

024 Code

Male

Low 1/3/5/6/7/8/9 Introverted or self-conscious or socially insecure, lacks social skills.

Nothing Low Introverted or self-conscious or socially insecure, lacks social skills, lacks skills with the opposite sex, tense, unhappy, worries a great deal, insomnia.

- Note: Scale 4 coded high was infrequently associated with lack of skills with the opposite sex.

Female

Low 1 Socially shy (02), lacks skills with the opposite sex (02, 24, 0-1), social extroversion (4—1), lacks self-confidence, indecisive, physical inferiority, father conflict, depressed, anxieties.

Low 3 Socially shy, lacks skills with the opposite sex, socially insecure (0-3), lacks self-confidence, indecisive, father conflict, depressed, anxieties.

- Note: Scale 4 coded high was infrequently associated with social insecurity.

Low 5 Socially shy, lacks skills with the opposite sex, socially insecure (2-5), shy in the interview (0-5), lacks self-confidence, indecisive, father conflict, rebellious toward home, mother conflict, depressed, anxieties, nervous, tense on examinations, wants answers.

- Note: Scale 4 coded high was infrequently associated with social insecurity and shyness in the interview.

Low 6 Socially shy, lacks skills with the opposite sex, socially insecure (2-6), lacks self-confidence, indecisive, father conflict, depressed, exhaustion, vague goals, nonverbal.

- Note: Scale 4 coded high was infrequently associated with social insecurity.

Low 7/8 Socially shy, lacks skills with the opposite sex, lacks self-confidence, indecisive, father conflict, depressed, anxieties.

Low 9 Socially shy, lacks skills with the opposite sex, lacks self-confidence, indecisive, father conflict, mother conflict, depressed, anxieties.

Nothing Low Socially shy, lacks skills with the opposite sex, lacks self-confidence, indecisive, father conflict, mother conflict, depressed, anxieties, nonverbal,

(Drake & Oetting, 1959)

025 Code

Male

Low 1 Introverted or self-conscious or socially insecure, shy in the interview, lacks social skills, wants reassurance only, restless, worries a great deal.

Low 3/4/6/7/8/9 Introverted or self-conscious or socially insecure, shy in the interview, lacks social skills, wants reassurance only, worries a great deal.

Nothing Low Introverted or self-conscious or socially insecure, shy in the interview, lacks social skills, lacks skills with the opposite sex, home conflict, wants reassurance only, tense, unhappy, worries a great deal, insomnia.

- Note: Scale 5 coded high was infrequently associated with tension.

Female

Low 1 Socially shy, lacks skills with the opposite sex, lacks self-confidence, physical inferiority.

- Note: Scale 5 coded high was infrequently associated with social shyness.

Low 3 Socially shy, lacks skills with the opposite sex, socially insecure, lacks self-confidence.

- Note: Scale 5 coded high was infrequently associated with social shyness.

Low 4 Socially shy, lacks skills with the opposite sex, lacks self-confidence.

- Note: Scale 5 coded high was infrequently associated with social shyness.

Low 6 Socially shy (02), lacks skills with the opposite sex, socially insecure, lacks self-confidence, nonverbal.

- Note: Scale 5 coded high was infrequently associated with social shyness.

Low 7/8 Socially shy (02), lacks skills with the opposite sex, lacks self-confidence.

- Note: Scale 5 coded high was infrequently associated with social shyness.

Low 9 Socially shy, lacks skills with the opposite sex, lacks self-confidence, mother conflict.

- Note: Scale 5 coded high was infrequently associated with social shyness.

Nothing Low Socially shy, lacks skills with the opposite sex, lacks self-confidence, depressed, nonverbal, distractible in study.

- Note: Scale 5 coded high was infrequently associated with social shyness.

(Drake & Oetting, 1959)

026 Code

Male

Low 1/3/4/5/7/8/9 Introverted or self-conscious or socially insecure, lacks social skills.

Nothing Low Introverted or self-conscious or socially insecure, lacks social skills, lacks skills with the opposite sex, tense, unhappy, worries a great deal, insomnia.

Female

Low 1 Socially shy, lacks skills with the opposite sex, lacks self-confidence, physical inferiority, 8-f conferences, anxieties.

Low 3 Socially shy, lacks skills with the opposite sex, socially insecure, lacks self-confidence, physical inferiority, anxieties, 8+ conferences.

Low 4 Socially shy, lacks skills with the opposite sex, shy in the interview, lacks self-confidence, physical inferiority, anxieties, 8+ conferences.

Low 5 Socially shy, lacks skills with the opposite sex, shy in the interview, socially insecure, lacks self-confidence, physical inferiority, indecisive, depressed, anxieties, nervous, tense on examinations, nonresponsive, wants answers, 8+ conferences.

Low 7/8 Socially shy, lacks skills with the opposite sex, lacks self-confidence, physical inferiority, anxieties, 8+ conferences.

Low 9 Socially shy, lacks skills with the opposite sex, lacks self-confidence, physical inferiority, anxieties, 8+ conferences, mother conflict.

Nothing Low Socially shy, lacks skills with the opposite sex, lacks self-confidence, physical inferiority, depressed, anxieties, restless, 8+ conferences, nonverbal.

(Drake & Oetting, 1959)

027 Code

Male

Low 1 Introverted or self-conscious or socially insecure, shy in the interview, lacks social skills, mother conflict, nonresponsive or nonverbal, tense, tense on examinations, indecisive, unhappy, worries a great deal, confused, home conflict.

Low 3/4/5/6/8 Introverted or self-conscious or socially insecure, shy in the interview, lacks social skills, mother conflict, tense, tense on examinations, indecisive, imhappy, worries a great deal.

Low 9 Introverted or self-conscious or socially insecure, shy in the interview, lacks social skills, mother conflict, generally dependent, tense, tense on examinations, indecisive, unhappy, worries a great deal.

Nothing Low Introverted or self-conscious or socially insecure, shy in the interview, lacks social skills, lacks skills with the opposite sex, home conflict, mother conflict, sibling conflict, nonresponsive or nonverbal, tense, tense on examinations, indecisive, unhappy, worries a great deal, insomnia, confused.

Female

Low 1 Socially shy, lacks skills with the opposite sex, socially insecure, lacks self-confidence, physical inferiority, depressed, anxieties, 4 to 7 conferences, distractible in study.

Low 3 Socially shy, lacks skills with the opposite sex, socially insecure, lacks self-confidence, depressed, anxieties, 4 to 7 conferences, cried in the interview, distractible in study.

Low 4 Socially shy, lacks skills with the opposite sex, socially insecure, lacks self-confidence, depressed, anxieties, 4 to 7 conferences, distractible in study.

Low 5 Socially shy, lacks skills with the opposite sex, socially insecure, shy in the interview, lacks self-confidence, indecisive, depressed, anxieties, 4 to 7 conferences, wants answers, distractible in study, tense on examinations, insomnia, exhaustion, nervous, headaches.

Low 6 Socially shy, lacks skills with the opposite sex, socially insecure, lacks self-confidence, depressed, anxieties, 4 to 7 conferences, nonverbal, distractible in study.

Low 8 Socially shy, lacks skills with the opposite sex, socially insecure, lacks self-confidence, depressed, anxieties, 4 to 7 conferences, distractible in study.

Low 9 Socially shy, lacks skills with the opposite sex, socially insecure, lacks self-confidence, depressed, anxieties, 4 to 7 conferences, distractible in study, mother conflict.

Nothing Low Socially shy, lacks skills with the opposite sex, socially insecure, lacks self-confidence, depressed, anxieties, headaches, 4 to 7 conferences, nonverbal, distractible in study, sibling conflict.

(Drake & Oetting, 1959)

028 Code

Male

Low 1/3/4/5/6/7/9 Introverted or self-conscious or socially insecure, lacks social skills, lacks skills with the opposite sex.

Nothing Low Introverted or self-conscious or socially insecure, lacks social skills, lacks skills with the opposite sex, tense, indecisive, unhappy, worries a great deal, insomnia, confused.

Female

Low 1 Socially shy, lacks skills with the opposite sex, socially insecure, lacks self-confidence, physical inferiority, depressed, anxieties, nervous, nonverbal, distractible in study.

Low 3 Socially shy, lacks skills with the opposite sex, socially insecure, shy in the interview, lacks self-confidence, depressed, anxieties, nervous, nonverbal, distractible in study.

Low 4 Socially shy, lacks skills with the opposite sex, shy in the interview, lacks self-confidence, depressed, anxieties, nervous, nonverbal, distractible in study.

Low 5 Socially shy, lacks skills with the opposite sex, socially insecure, shy in the interview, lacks self-confidence, indecisive, depressed, anxieties, nervous, nonverbal, wants answers, distractible in study, tense on examinations.

Low 6 Socially shy, lacks skills with the opposite sex, socially insecure, shy in the interview, lacks self-confidence, depressed, anxieties, nervous, nonverbal, distractible in study.

Low 7 Socially shy, lacks skills with the opposite sex, shy in the interview, lacks self-confidence, depressed, anxieties, nervous, nonverbal, distractible in study.

Low 9 Socially shy, lacks skills with the opposite sex, socially insecure, lacks self-confidence, depressed, anxieties, nervous, nonverbal, distractible in study, mother conflict.

Nothing Low Socially shy, lacks skills with the opposite sex, socially insecure, lacks self-confidence, depressed, anxieties, nervous, nonverbal, 8+ conferences, distractible in study, mother conflict, father conflict, sibling conflict.
(Drake & Oetting, 1959)

029 Code

Male

Low 1/3/4/5/6/7/8 Introverted or self-conscious or socially insecure, lacks social skills, tense on examinations, aggressive or belligerent, rationalizes a great deal.

Nothing Low Introverted or self-conscious or socially insecure, lacks social skills, lacks skills with the opposite sex, tense, tense on examinations, unhappy, worries a great deal, insomnia, aggressive or belligerent, rationalizes a great deal.

- Note: Scale 9 coded high was infrequently associated with lack of skills with the opposite sex and worrying a great deal.

Female

Low 1 Socially shy (09, 02, 09-1), lacks skills with the opposite sex, socially insecure (29), socially extroverted (9-1), lacks self-confidence, physical inferiority, vague goals.

Low 3 Socially shy, lacks skills with the opposite sex, socially insecure, lacks self-confidence, vague goals.

Low 4 Socially shy, lacks skills with the opposite sex, socially insecure, shy in the interview (9-4), lacks self-confidence, nonresponsive.

- Note: Scale 9 coded high was infrequently associated with shyness in the interview.

Low 5 Socially shy, lacks skills with the opposite sex, socially insecure, shy in the interview (0-5), lacks self-confidence, indecisive, depressed, anxieties, nervous, exhaustion, verbal, wants answers, tense on examinations.

- Note: Scale 9 coded high was infrequently associated with shyness in the interview.

Low 6 Socially shy, lacks skills with the opposite sex, socially insecure, lacks self-confidence, nonverbal.

Low 7/8 Socially shy, lacks skills with the opposite sex, socially insecure, lacks self-confidence.

Nothing Low Socially shy, lacks skills with the opposite sex, socially insecure, lacks self-confidence, nonverbal, depressed.

(Drake & Oetting, 1959)

03/30 Codes

See 30/03 Codes.

Male

Low 1/9 Introverted or self-conscious or socially insecure.

Female

Low 1 Lacks skills with the opposite sex.

Low 2 Socially extroverted (3-2).

Low 5 Socially shy, shy in the interview, exhaustion, insomnia, headaches, home conflict, distractible in study.

Low 9 Socially shy.

Nothing Low Socially shy, lacks skills with the opposite sex, nonverbal (0-X), verbal (3-X), father conflict, mother conflict, tense on examinations.

(Drake & Oetting, 1959)

034 Code

Male

Low 1/9 Introverted or self-conscious or socially insecure.

Female

Low 1 Lacks skills with the opposite sex, socially extroverted (4-1), father conflict, home conflict, lacks academic drive.

Low 2 Socially extroverted, father conflict (04), family conflict (34), lacks academic drive.

- Note: Scale 2 coded low was infrequently associated with father or family conflict.

Low 5 Socially shy, lacks skills with the opposite sex, shy in the interview (0-5) father conflict, home conflict, rebellious toward home, anxieties, exhaustion, insomnia, headaches, lacks academic drive, distractible in study, indecisive.

- Note Scale 4 coded high was infrequently associated with shyness in the interview.

Low 6 Father conflict, home conflict, lacks academic drive, vague goals.

Low 7/8 Father conflict, home conflict, lacks academic drive.

Low 9 Socially shy, father conflict, home conflict, lacks academic drive.

Nothing Low Socially shy, lacks skills with the opposite sex, father conflict, home conflict, mother conflict, lacks academic drive, nonverbal (0-X), verbal (3-X), tense on examinations.

(Drake & Oetting, 1959)

035 Code

Male

Low 1 Introverted or self-conscious or socially insecure, shy in the interview, home dependency, four or more conferences, restless.

- Note: Scale 3 coded high was infrequently associated with restlessness.

Low 2/4/6/7/8/9 Introverted or self-conscious or socially insecure, shy in the interview, home dependency, four or more conferences.

Nothing Low Introverted or self-conscious or socially insecure, shy in the interview, lacks skills with the opposite sex, home dependency, home conflict, four or more conferences, insomnia.

Female

Low 1 Lacks skills with the opposite sex.

Low 2 Socially extroverted (3-2).

Low 9 Socially shy (0-9).

- Note: Scale 5 coded high was infrequently associated with social shyness.

Nothing Low Socially shy (0-X), lacks skills with the opposite sex, father conflict (3-X), mother conflict, nonverbal (0-X), verbal (3-X), tense on examinations, distractible in study.

- Note: Scale 5 coded high was infrequently associated with social shyness and father conflict.

(Drake & Oetting, 1959)

036 Code

Male

Low 1/9 Introverted or self-conscious or socially insecure.

Female

Low 1 Socially shy, lacks skills with the opposite sex, physical inferiority.

Low 2 Socially shy (06), social extroversion (3-2), physical inferiority.

- Note: Scale 2 coded low was infrequently associated with social shyness.

Low 4 Socially shy, shy in the interview, physical inferiority.

Low 5 Socially shy, shy in the interview, exhaustion, insomnia, headaches, home conflict, physical inferiority, distractible in study.

Low 9 Socially shy, physical inferiority.

Nothing Low Socially shy, lacks skills with the opposite sex, physical inferiority, father conflict, mother conflict, nonverbal (0-X), verbal (3-X), 8+ conferences, restless, tense on examinations.

(Drake & Oetting, 1959)

037 Code

Male

Low 1 Introverted or self-conscious or socially insecure, shy in the interview, mother conflict, nonresponsive or nonverbal, indecisive, unhappy.

- Note: Scale 3 coded high was infrequently associated with mother conflict.

Low 2/4/5/6/8/9 Introverted or self-conscious or socially insecure, shy in the interview, mother conflict, indecisive, unhappy (07).

- Note: Scale 3 coded high was infrequently associated with mother conflict.

Nothing Low Introverted or self-conscious or socially insecure, shy in the interview, lacks skills with the opposite sex, mother conflict, sibling conflict, nonresponsive or nonverbal, tense, indecisive, unhappy, worries a great deal, insomnia, confused.

- Note: Scale 3 coded high was infrequently associated with mother conflict.

Female

Low 1 Socially shy, socially insecure, lacks skills with the opposite sex, anxieties, insomnia, lacks self-confidence.

Low 2 Socially shy (07), socially insecure (07), socially extroverted (3-2), anxieties, insomnia, lacks self-confidence (07).

- Note: Scale 2 coded low was infrequently associated with social shyness, social insecurity, lack of self-confidence.

Low 4 Socially shy, socially insecure, anxieties, insomnia, lacks self-confidence.

Low 5 Socially shy, socially insecure, shy in the interview, anxieties, insomnia, exhaustion, nervous, headaches, lacks self-confidence, indecisive, home conflict, distractible in study.

Low 6/8/9 Socially shy, socially insecure, anxieties, insomnia, lacks self-confidence.

Nothing Low Socially shy, socially insecure, lacks skills with the opposite sex, anxieties, insomnia, headaches, lacks self-confidence, father conflict, mother conflict, sibling conflict, tense on examinations, nonverbal (0-X), verbal (3-X).

(Drake & Oetting, 1959)

038 Code

Male

Low 1 Introverted or self-conscious or socially insecure, lacks knowledge or information.

Low 2/4/5/6/7 Lacks knowledge or information.

Low 9 Introverted or self-conscious or socially insecure, lacks knowledge or information.

Nothing Low Indecisive, unhappy, worries a great deal, insomnia, lacks knowledge or information, confused.

Female

Low 1 Socially shy, lacks skills with the opposite sex, shy in the interview, nonverbal (08), verbal (38), nervous.

Low 2 Socially shy (08), shy in the interview, socially extroverted (3-2), nonverbal (08), verbal (38), nervous.

- Note: Scale 2 coded low was infrequently associated with social shyness.

Low 4 Socially shy, shy in the interview, nonverbal (08), verbal (38), nervous.

Low 5 Socially shy, shy in the interview, nonverbal (08, 08-5), verbal (38, 38-5), anxious, nervous, exhaustion, insomnia, headaches, home conflict, distractible in study.

Low 6/7/9 Socially shy, shy in the interview, nonverbal (08), verbal (38), nervous.

Nothing Low Socially shy, shy in the interview, lacks skills with the opposite sex, nonverbal (08, 0-X), verbal (38, 3-X), 8+ conferences, nervous, depressed, father conflict, mother conflict, sibling conflict, tense on examinations.

(Drake & Oetting, 1959)

039 Code

Male

Low 1 Introverted or self-conscious or socially insecure.

Low 6 Rationalizes a great deal.

Female

Low 1 Socially shy (09), lacks skills with the opposite sex, socially extroverted (39, 9-1), vague goals, marriage oriented.

Low 2 Socially shy (09), socially extroverted (39, 9-2, 3-2), marriage oriented.

- Note: Scale 2 coded low was infrequently associated with social shyness.

Low 4 Socially shy (09), shy in the interview (9-4), socially extroverted (39), marriage oriented, nonresponsive (9-4).

- Note: Scale 3 coded high was infrequently associated with nonresponsiveness.

Low 5 Socially shy (09, 0-5), shy in the interview (0-5), socially extroverted (39), marriage oriented, distractible in study, exhaustion, insomnia, headaches, home conflict, verbal.

Low 6/7/8 Socially shy (09), socially extroverted (39), marriage oriented.

Nothing Low Socially shy (09, 0-X) , lacks skills with the opposite sex, socially extroverted (39), marriage oriented.
(Drake & Oetting, 1959)

[04/40 Codes](#)

See 40/04 Codes.

Male

Low 1/9 Introverted or self-conscious or socially insecure.

Female

Low 1 Lacks skills with the opposite sex, socially extroverted (4—1), father conflict.

Low 2 Socially extroverted (4-2), father conflict.

- Note: Scale 2 coded low was infrequently associated with father conflict.

Low 3 Socially insecure, father conflict.

- Note: Scale 4 coded high was infrequently associated with social insecurity.

Low 5 Socially shy, lacks skills with the opposite sex, shy in the interview, father conflict, rebellious toward home, indecisive, anxieties.

- Note: Scale 4 coded high was infrequently associated with shyness in the interview.

Low 6 Father conflict, vague goals.

Low 7/8 Father conflict.

Low 9 Father conflict, socially shy.

Nothing Low Father conflict, socially shy, lacks skills with the opposite sex, nonverbal.

(Drake & Oetting, 1959)

045 Code

Male

Low 1 Introverted or self-conscious or socially insecure, shy in the interview, home conflict, restless.

Low 2/3/6/7/8/9 Introverted or self-conscious or socially insecure, shy in the interview.

Nothing Low Introverted or self-conscious or socially insecure, shy in the interview, home conflict, insomnia.

Female

Low 1 Father conflict, lacks skills with the opposite sex, socially extroverted.

- Note: Scale 5 coded high was infrequently associated with father conflict.

Low 2 Father conflict, socially extroverted (4-2) .

- Note: Scale 5 coded high was infrequently associated with father conflict.

Low 3 Father conflict, socially insecure.

- Note: Scale 4 coded high was infrequently associated with social insecurity; Scale 5 coded high was infrequently associated with father conflict.

Low 6/7/8 Father conflict, vague goals.

- Note: Scale 5 coded high was infrequently associated with father conflict.

Low 9 Father conflict, socially shy.

- Note: Scale 5 coded high was infrequently associated with father conflict.

Nothing Low Father conflict, socially shy, lacks skills with the opposite sex, nonverbal, distractible in study.

- Note: Scale 5 coded high was infrequently associated with social shyness; Scale 5 coded high was infrequently associated with father conflict.

(Drake & Oetting, 1959)

046 Code

Male

Low 1 Introverted or self-conscious or socially insecure, worries a great deal.

Low 2/3/5/7/8 Worries a great deal.

Low 9 Introverted or self-conscious or socially insecure, worries a great deal.

Female

Low 1 Socially shy (06), lacks skills with the opposite sex, socially extroverted (4-1), father conflict, physical inferiority.

Low 2 Socially shy (06) , socially extroverted (4-2, 6-2) , father conflict, physical inferiority.

- Note: Scale 2 coded low was infrequently associated with social shyness or father conflict.

Low 3 Socially shy, socially insecure, father conflict, physical inferiority.

- Note: Scale 4 coded high was infrequently associated with social insecurity,

Low 5 Socially shy, shy in the interview, lacks skills with the opposite sex, father conflict, rebellious toward home, physical inferiority, indecisive, anxieties.

- Note: Scale 4 coded high was infrequently associated with shyness in the interview.

Low 7/8/9 Socially shy, father conflict, physical inferiority.

Nothing Low Socially shy, lacks skills with the opposite sex, father conflict, nonverbal, 8+ conferences, restless.

(Drake & Oetting, 1959)

047 Code

Male

Low 1 Introverted or self-conscious or socially insecure, shy in the interview, home conflict, mother conflict, indecisive, unhappy, nonresponsive or nonverbal.

Low 2/3/5/6/8/9 Introverted or self-conscious or socially insecure, shy in the interview, home conflict, mother conflict, indecisive, unhappy (07).

Nothing Low Introverted or self-conscious or socially insecure, shy in the interview, lacks skills with the opposite sex, home conflict, mother conflict, sibling conflict, indecisive, tense, unhappy, worries a great deal, insomnia, confused, nonresponsive or nonverbal, poor rapport.

- Note: Scale 4 coded high was infrequently associated with lack of skills with the opposite sex.

Female

Low 1 Socially shy (07), socially insecure (07), lacks skills with the opposite sex, socially extroverted (4—1), father conflict, rebellious toward home, lacks self-confidence, insomnia.

- Note: Scale 4 coded high was infrequently associated with social insecurity.

Low 2 Socially shy (07), socially insecure (07), socially extroverted (4-2), father conflict, rebellious toward home, lacks self-confidence.

- Note: Scale 2 coded low was infrequently associated with social shyness, father conflict, lack of self-confidence; Scale 4 coded high was infrequently associated with social insecurity.

Low 3 Socially shy, socially insecure, father conflict, rebellious toward home, lacks self-confidence, insomnia, cried in the interview.

- Note: Scale 4 coded high was infrequently associated with social insecurity.

Low 5 Socially shy, socially insecure, shy in the interview, lacks skills with the opposite sex, father conflict, rebellious toward home, anxieties, insomnia, exhaustion, nervous, headaches, indecisive, lacks self-confidence.

- Note: Scale 4 coded high was infrequently associated with social insecurity.

Low 6 Socially shy, socially insecure, father conflict, rebellious toward home, insomnia, vague goals, lacks self-confidence.

- Note: Scale 4 coded high was infrequently associated with social insecurity.

Low 8/9 Socially shy, socially insecure, father conflict, rebellious toward home, insomnia, lacks self-confidence.

- Note: Scale 4 coded high was infrequently associated with social insecurity.

Nothing Low Socially shy, socially insecure, lacks skills with the opposite sex, father conflict, rebellious toward home, sibling conflict, insomnia, headaches, nonverbal, tense on examinations, lacks self-confidence.

- Note: Scale 4 coded high was infrequently associated with social insecurity.

(Drake & Oetting, 1959)

048 Code

Male

Low 1/9 Introverted or self-conscious or socially insecure.

Nothing Low Indecisive, unhappy, worries a great deal, insomnia, confused.

Female

Low 1 Socially shy (08), shy in the interview (08), lacks skills with the opposite sex, socially extroverted (4-1), father conflict, overprotective mother, depressed, insomnia, nervous, nonverbal.

- Note: Scale 4 coded high was infrequently associated with shyness in the interview.

Low 2 Socially shy (08), shy in the interview (08), socially extroverted (4-2), father conflict, overprotective mother, depressed (48), insomnia, nervous, nonverbal.

- Note: Scale 2 coded low was infrequently associated with social shyness and father conflict; Scale 4 coded high was infrequently associated with shyness in the interview.

Low 3 Socially shy, socially insecure, shy in the interview, father conflict, overprotective mother, depressed, insomnia, nervous, nonverbal.

- Note: Scale 4 coded high was infrequently associated with shyness in the interview.

Low 5 Socially shy, shy in the interview, lacks skills with the opposite sex, father conflict, overprotective mother, rebellious toward home, depressed, insomnia, nervous, anxieties, distractible in study, nonverbal, indecisive.

- Note: Scale 4 coded high was infrequently associated with shyness in the interview.

Low 6 Socially shy, shy in the interview, father conflict, overprotective mother, depressed, insomnia, nervous, vague goals, nonverbal.

- Note: Scale 4 coded high was infrequently associated with shyness in the interview.

Low 7/9 Socially shy, shy in the interview, father conflict, overprotective mother, depressed, insomnia, nervous, nonverbal.

- Note: Scale 4 coded high was infrequently associated with shyness in the interview.

Nothing Low Socially shy, shy in the interview, lacks skills with the opposite sex, father conflict, overprotective mother, mother conflict, sibling conflict, depressed, insomnia, headaches, nervous, 8+ conferences, nonverbal.
(Drake & Oetting, 1959)

049 Code

Male

Low 1 Introverted or self-conscious or socially insecure.

Low 2 Aggressive or belligerent.

Low 6 Rationalizes a great deal.

Female

Low 1 Socially shy (09, 09-1), lacks skills with the opposite sex, socially extroverted (49, 4-1), father conflict, home conflict, vague goals, verbal.

Low 2 Socially shy (09), socially extroverted (49, 4-2), father conflict, family conflict, vague goals, verbal.

- Note: Scale 2 coded low was infrequently associated with social shyness, father conflict, family conflict.

Low 3 Socially shy (09), socially insecure (0-3), socially extroverted (49), father conflict, family conflict, vague goals, verbal.

- Note: Scale 4 coded high was infrequently associated with social insecurity.

Low 5 Socially shy (09, 0-5), shy in the interview (0-5), lacks skills with the opposite sex, socially extroverted (49), father conflict, family conflict, rebellious toward home, vague goals, verbal (49, 9-5), indecisive, anxieties, exhaustion.

Low 6/7/8 Socially shy (09), socially extroverted (49), father conflict, family conflict, vague goals, verbal.

Nothing Low Socially shy (09, 0-X), lacks skills with the opposite sex, socially extroverted (49), father conflict, family conflict, vague goals, verbal (49), non-verbal (0-X)
(Drake & Oetting, 1959)

05/50 Codes

See 50/05 Codes.

Male

05-1 Introverted or self-conscious or socially insecure, shy in the interview, restless.

Low 2/3/4/6/7/8/9 Introverted or self-conscious or socially insecure, shy in the interview.

Nothing Low Introverted or self-conscious or socially insecure, shy in the interview, home conflict, insomnia.

Female

Low 1 Lacks skills with the opposite sex.

Low 3 Socially insecure.

Low 9 Socially shy.

- Note: Scale 5 coded high was infrequently associated with social shyness.

Nothing Low Socially shy, lacks skills with the opposite sex, nonverbal, distractible in study.

- Note: Scale 5 coded high was infrequently associated with social shyness.

(Drake & Oetting, 1959)

056 Code

Male

Low 1 Introverted or self-conscious or socially insecure, shy in the interview, restless.

Low 2/3/4/7/8/9 Introverted or self-conscious or socially insecure, shy in the interview.

Nothing Low Introverted or self-conscious or socially insecure, shy in the interview, home conflict, insomnia.

Female

Low 1 Socially shy, lacks skills with the opposite sex, physical inferiority.

- Note: Scale 5 coded high was infrequently associated with social shyness.

Low 2 Socially shy (06) , socially extroverted (6-2) , physical inferiority.

- Note: Scale 2 coded low was infrequently associated with social shyness; Scale 5 coded high was infrequently associated with social shyness.

Low 3 Socially shy, socially insecure, physical inferiority.

- Note: Scale 5 coded high was infrequently associated with social shyness.

Low 4 Socially shy, shy in the interview, physical inferiority.

- Note: Scale 5 coded high was infrequently associated with social shyness.

Low 7/8/9 Socially shy, physical inferiority.

- Note: Scale 5 coded high was infrequently associated with social shyness.

Nothing Low Socially shy, lacks skills with the opposite sex, physical inferiority, nonverbal, 8+ conferences, restless, distractible in study.

- Note: Scale 5 coded high was infrequently associated with 8+ conferences and social shyness.

(Drake & Oetting, 1959)

057 Code

Male

Low 1 Introverted or self-conscious or socially insecure, shy in the interview, home conflict, mother conflict, wants reassurance only, nonresponsive or nonverbal, indecisive, restless, unhappy.

Low 2/3/4/6/8/9 Introverted or self-conscious or socially insecure, shy in the interview, home conflict, mother conflict, wants reassurance only, indecisive, unhappy (07).

Nothing Low Introverted or self-conscious or socially insecure, shy in the interview, lacks skills with the opposite sex, home conflict, mother conflict, sibling conflict, wants reassurance only, nonresponsive or nonverbal, tense, indecisive, unhappy, worries a great deal, insomnia, confused.

- Note: Scale 5 coded high was infrequently associated with tension.

Female

Low 1 Socially shy, socially insecure, lacks skills with the opposite sex, lacks self-confidence.

- Note: Scale 5 coded high was infrequently associated with social shyness.

Low 2 Socially shy, socially insecure, lacks self-confidence.

- Note: Scale 2 coded low was infrequently associated with social shyness and lack of selfconfidence; Scale 5 coded high was infrequently associated with social shyness.

Low 3 Socially shy, socially insecure, lacks self-confidence, cried in the interview.

- Note: Scale 5 coded high was infrequently associated with social shyness.

Low 4/6/8/9 Socially shy, socially insecure, lacks self-confidence.

- Note: Scale 5 coded high was infrequently associated with social shyness.

Nothing Low Socially shy, socially insecure, lacks skills with the opposite sex, lacks self-confidence, nonverbal, sibling conflict, headaches, distractible in study.

- Note: Scale 5 coded high was infrequently associated with headaches and social shyness.

(Drake & Oetting, 1959)

058 Code

Male

Low 1 Introverted or self-conscious or socially insecure, shy in the interview, home conflict, restless.

Low 2/3/4/6/7/9 Introverted or self-conscious or socially insecure, shy in the interview, home conflict.

Nothing Low Introverted or self-conscious or socially insecure, shy in the interview, home conflict, indecisive, unhappy, worries a great deal, insomnia, confused.

Female

Low 1 Socially shy, shy in the interview, lacks skills with the opposite sex, nonverbal, nervous.

- Note: Scale 5 coded high was infrequently associated with social shyness.

Low 2 Socially shy, shy in the interview, nonverbal, nervous.

- Note: Scale 2 coded low was infrequently associated with social shyness; Scale 5 coded high was infrequently associated with social shyness.

Low 3 Socially shy, shy in the interview, socially insecure, nonverbal, nervous.

- Note: Scale 5 coded high was infrequently associated with social shyness.

Low 4/6/7/9 Socially shy, shy in the interview, nonverbal, nervous.

- Note: Scale 5 coded high was infrequently associated with social shyness.

Nothing Low Socially shy, shy in the interview, lacks skills with the opposite sex, nonverbal, 8+ conferences, depressed, nervous, father conflict, mother conflict, sibling conflict, distractible in study.

- Note: Scale 5 coded high was infrequently associated with social shyness.

(Drake & Oetting, 1959)

059 Code

Male

Low 1 Introverted or self-conscious or socially insecure, shy in the interview, mother conflict, poor rapport, restless.

Low 2/3/4 Introverted or self-conscious or socially insecure, shy in the interview, mother conflict, poor rapport.

Low 6 Introverted or self-conscious or socially insecure, shy in the interview, mother conflict, poor rapport, rationalizes a great deal.

Low 7/8 Introverted or self-conscious or socially insecure, shy in the interview, mother conflict, poor rapport.

Nothing Low Introverted or self-conscious or socially insecure, shy in the interview, home conflict, mother conflict, poor rapport, insomnia.

Female

Low 1 Socially shy (09), socially extroverted (59, 9-1), lacks skills with the opposite sex, vague goals.

- Note: Scale 5 coded high was infrequently associated with social shyness.

Low 2 Socially shy (09), socially extroverted (59, 9-2), vague goals.

- Note: Scale 2 coded low was infrequently associated with social shyness; Scale 5 coded high was infrequently associated with social shyness.

Low 3 Socially shy (09), socially insecure (0-3), socially extroverted (59), vague goals.

- Note: Scale 5 coded high was infrequently associated with social shyness.

Low 4 Socially shy (09), shy in the interview, socially extroverted (59), vague goals, nonresponsive.

- Note: Scale 9 coded high was infrequently associated with shyness in the interview; Scale 5 coded high was infrequently associated with social shyness.

Low 6/7/8 Socially shy (09), socially extroverted (59), vague goals.

- Note: Scale 5 coded high was infrequently associated with social shyness.

Nothing Low Socially shy (09), socially extroverted (59), lacks skills with the opposite sex, vague goals, distractible in study, nonverbal.

- Note: Scale 5 coded high was infrequently associated with social shyness.

(Drake & Oetting, 1959)

06/60 Codes

See 60/06 Codes.

Male

Low 1/9 Introverted or self-conscious or socially insecure.

Female

Low 1 Socially shy, lacks skills with the opposite sex, physical inferiority.

Low 2 Socially shy (06), socially extroverted (6-2), physical inferiority.

- Note: Scale 2 coded low was infrequently associated with social shyness.

Low 3/4/5 Socially shy, socially insecure, physical inferiority.

Low 7/8/9 Socially shy, physical inferiority.

Nothing Low Socially shy, lacks skills with the opposite sex, physical inferiority, nonverbal, 8+ conferences, restless.

(Drake & Oetting, 1959)

067 Code

Male

Low 1 Introverted or self-conscious or socially insecure, shy in the interview, mother conflict, indecisive, unhappy, nonresponsive or nonverbal.

Low 2/4/5/8/9 Introverted or self-conscious or socially insecure, shy in the interview, mother conflict, indecisive, unhappy (07).

Nothing Low Introverted or self-conscious or socially insecure, shy in the interview, lacks skills with the opposite sex, mother conflict, sibling conflict, indecisive, tense, unhappy, worries a great deal, insomnia, confused, nonresponsive or nonverbal.

Female

Low 1 Socially shy, socially insecure, lacks skills with the opposite sex, physical inferiority, lacks self-confidence.

Low 2 Socially shy (06, 07) , socially insecure (07) , socially extroverted (6-2) physical inferiority, lacks self-confidence.

- Note: Scale 2 coded low was infrequently associated with social shyness, social insecurity, lack of self-confidence.

Low 3 Socially shy, socially insecure, physical inferiority, lacks self-confidence, cried in the interview.

Low 4 Socially shy, socially insecure, shy in the interview, physical inferiority, lacks self-confidence.

Low 5 Socially shy, socially insecure, shy in the interview, physical inferiority, lacks self-confidence, indecisive, anxieties, nervous, exhaustion, insomnia, headaches.

Low 8/9 Socially shy, socially insecure, physical inferiority, lacks self-confidence.

Nothing Low Socially shy, socially insecure, lacks skills with the opposite sex, physical inferiority, lacks self-confidence, restless, headaches, sibling conflict, nonverbal, 8+ conferences.

(Drake & Oetting, 1959)

068 Code

Male

Low 1/9 Introverted or self-conscious or socially insecure.

Nothing Low Indecisive, unhappy, worries a great deal, insomnia, confused.

Female

Low 1 Socially shy, shy in the interview, lacks skills with the opposite sex, physical inferiority, nonverbal, 8+ conferences, nervous.

Low 2 Socially shy (06, 08), shy in the interview, socially extroverted (6-2), physical inferiority, nonverbal, 8+ conferences, nervous.

- Note: Scale 2 coded low was infrequently associated with social shyness.

Low 3 Socially shy, shy in the interview, socially insecure, physical inferiority, nonverbal, 8+ conferences, nervous.

Low 4 Socially shy, shy in the interview, physical inferiority, nonverbal, 8+ conferences, nervous.

Low 5 Socially shy, shy in the interview, physical inferiority, nonverbal, 8 + conferences, anxieties, nervous, distractible in study.

Low 7/9 Socially shy, shy in the interview, physical inferiority, nonverbal, 8 + conferences, nervous.

Nothing Low Socially shy, shy in the interview, lacks skills with the opposite sex, physical inferiority, nonverbal, 8+ conferences, depressed, restless, nervous, father conflict, mother conflict, sibling conflict.

(Drake & Oetting, 1959)

069 Code

Male

Low 1 Introverted or self-conscious or socially insecure.

Female

Low 1 Socially shy (06, 09), socially extroverted (9-1), lacks skills with the opposite sex, physical inferiority, vague goals.

Low 2 Socially shy (06, 09) , socially extroverted (9-2, 6-2) , physical inferiority.

- Note: Scale 2 coded low was infrequently associated with social shyness,

Low 3 Socially shy, socially insecure, physical inferiority, vague goals.

Low 4 Socially shy, shy in the interview, physical inferiority, nonresponsive.

- Note: Scale 9 coded high was infrequently associated with shyness in the interview.

Low 5 Socially shy, shy in the interview, physical inferiority, verbal, exhaustion.

- Note: Scale 9 coded high was infrequently associated with shyness in the interview.

Low 7/8 Socially shy, physical inferiority.

Nothing Low Socially shy, lacks skills with the opposite sex, physical inferiority, nonverbal, 8+ conferences, restless.

(Drake & Oetting, 1959)

07/70 Codes

See 70/07 Codes.

The men in the counselee group studied by Drake and Oetting presented a depressed picture in that they were described as unhappy, tense, confused, worrying a great deal, and suffering insomnia. They were shy in the interview and gave the impression of being generally introverted and insecure. They were often characterized as nonresponsive or nonverbal. They were also markedly indecisive and had several conflict areas centering around their home life and their relationships with their mothers and siblings, as well as their effectiveness in relating to members of the opposite sex. College women with this pattern seen by Drake and Oetting did not generally show this complete picture. Their problems centered about social insecurity, self-consciousness, and lack of confidence. They too had difficulties in relationships with the opposite sex, and occasionally had feelings of physical inferiority. When this high-point pattern was combined with a low point on scale 5, the rest of the features noted above for males with this code type appeared in the female counselees as well. That is, these women appeared nervous and indecisive, worried and anxious, and were notably shy in the interview. They also complained of insomnia, headaches, and exhaustion. (Dahlstrom, Welsh, & Dahlstrom, 1979)

Male

Low 1 Introverted or self-conscious or socially insecure, shy in the interview, mother conflict, indecisive, unhappy, nonresponsive or nonverbal, home conflict.

Low 2/3/4/5/6/8/9 Introverted or self-conscious or socially insecure, shy in the interview, mother conflict, indecisive, unhappy (07).

Nothing Low Introverted or self-conscious or socially insecure, shy in the interview, lacks skills with the opposite sex, mother conflict, sibling conflict, indecisive, tense, unhappy, worries a great deal, insomnia, confused, nonresponsive or nonverbal.

Female

Low 1 Socially shy, socially insecure, lacks skills with the opposite sex, lacks self-confidence.

Low 2 Socially shy, socially insecure, lacks self-confidence.

- Note: Scale 2 coded low was infrequently associated with social shyness, social insecurity, lack of self-confidence.

Low 3 Socially shy, socially insecure, lacks self-confidence, cried in the interview.

Low 4 Socially shy, socially insecure, lacks self-confidence.

Low 5 Socially shy, socially insecure, shy in the interview, lacks self-confidence, indecisive, anxieties, exhaustion, nervous, insomnia, headaches.

Low 6/8/9 Socially shy, socially insecure, lacks self-confidence.

Nothing Low Socially shy, socially insecure, lacks skills with the opposite sex, lacks self-confidence, sibling conflict, nonverbal, headaches.

(Drake & Oetting, 1959)

078 Code

Male

Low 1/2/3/4/5/6/9 Introverted or self-conscious or socially insecure, shy in the interview, mother conflict, nonresponsive or nonverbal, tense, indecisive, unhappy (07), lacking in knowledge or information, vague goals, confused.

Nothing Low Introverted or self-conscious or socially insecure, shy in the interview, lacks skills with the opposite sex, mother conflict, sibling conflict, nonresponsive or nonverbal, tense, indecisive, unhappy, lacks knowledge or information, vague goals, confused, worries a great deal, insomnia.

Female

Low 1 Socially shy, socially insecure, shy in the interview, lacks skills with the opposite sex, lacks self-confidence, nonverbal, nervous, insomnia.

Low 2 Socially shy, socially insecure, shy in the interview, lacks skills with the opposite sex, lacks self-confidence, nonverbal, nervous, insomnia.

- Note: Scale 2 coded low was infrequently associated with social shyness, social insecurity, lack of self-confidence.

Low 3 Socially shy, socially insecure, shy in the interview, lacks self-confidence, nonverbal, cried in the interview, nervous, insomnia.

Low 4 Socially shy, socially insecure, shy in the interview, lacks self-confidence, nonverbal, nervous, insomnia.

Low 5 Socially shy, socially insecure, shy in the interview, lacks self-confidence, indecisive, nonverbal, anxieties, nervous, insomnia, exhaustion, headaches, distractible in study.

Low 6/9 Socially shy, socially insecure, shy in the interview, lacks self-confidence, nonverbal, nervous, insomnia.

Nothing Low Socially shy, socially insecure, shy in the interview, lacks skills with the opposite sex, lacks self-confidence, nonverbal, 8+ conferences, nervous, insomnia, exhaustion, depressed, headaches, father conflict, mother conflict, sibling conflict.

(Drake & Oetting, 1959)

079 Code

Male

Low 1 Introverted or self-conscious or socially insecure, shy in the interview, home conflict, mother conflict, nonresponsive or nonverbal, indecisive, unhappy, defensive.

- Note: Scale 9 coded high was infrequently associated with being nonresponsive or nonverbal and with indecisiveness.

Low 2/3/4/5 Introverted or self-conscious or socially insecure, shy in the interview, home conflict, mother conflict, indecisive, unhappy (07), defensive.

- Note: Scale 9 coded high was infrequently associated with indecisiveness.

Low 6 Introverted or self-conscious or socially insecure, shy in the interview, home conflict, mother conflict, indecisive, unhappy, defensive, rationalizes a great deal.

- Note: Scale 9 coded high was infrequently associated with indecisiveness.

Low 8 Introverted or self-conscious or socially insecure, shy in the interview, home conflict, mother conflict, unhappy, defensive, indecisive.

- Note: Scale 9 coded high was infrequently associated with indecisiveness.

Nothing Low Introverted or self-conscious or socially insecure, shy in the interview, lacks skills with the opposite sex, home conflict, mother conflict, sibling conflict, nonresponsive or nonverbal, tense, indecisive, unhappy, worries a great deal, insomnia, confused, defensive.

- Note: Scale 9 coded high was infrequently associated with lack of skills with the opposite sex, being nonresponsive or nonverbal, indecisiveness, worrying a great deal.

Female

Low 1 Socially shy (07, 09), socially insecure (07), lacks skills with the opposite sex, socially extroverted (9-1), lacks self-confidence, confused, sibling conflict, nervous, distractible in study, vague goals.

Low 2 Socially shy (07, 09), socially insecure (07), socially extroverted (9-2), lacks self-confidence, confused, sibling conflict, nervous, distractible in study.

- Note: Scale 2 coded low was infrequently associated with social shyness, social insecurity, lack of self-confidence.

Low 3 Socially shy, socially insecure, lacks self-confidence, sibling conflict, nervous, distractible in study, vague goals, cried in the interview.

Low 4 Socially shy, socially insecure, shy in the interview, lacks self-confidence, confused, sibling conflict, nervous, distractible in study, nonresponsive.

- Note: Scale 9 coded high was infrequently associated with shyness in the interview.

Low 5 Socially shy, socially insecure, shy in the interview, lacks self-confidence, confused, indecisive, sibling conflict, nervous, exhaustion, insomnia, headaches, anxieties, verbal, distractible in study.

- Note: Scale 9 coded high was infrequently associated with shyness in the interview.

Low 6/8 Socially shy, socially insecure, lacks self-confidence, confused, sibling conflict, nervous, distractible in study.

Nothing Low Socially shy, socially insecure, lacks skills with the opposite sex, lacks self-confidence, confused, sibling conflict, nervous, headaches, distractible in study, nonverbal.

(Drake & Oetting, 1959)

08/80 Codes

See 80/08 Codes.

The counselees seen by Drake and Oetting with this code type showed some of the same features as the 07' s, but the men did not demonstrate the social insecurity to the same extent. Rather they gave evidence of worries, confusion, and insomnia. They were also indecisive and unhappy. The women showed the more complete pattern of nervousness, social insecurity, shyness, and self-consciousness. They had many areas of conflict, significantly shifting from a mother conflict to one with the father. Recurring in many of the reports was the comment that these female counselees were nonrelators. The women had serious problems, particularly noted when scale 5 was the low point in

this pattern, and they usually came back to the center for a number of interviews.

(Dahlstrom, Welsh, & Dahlstrom, 1979)

- Counselors with a high 0-8 combination tend to be shy and have problems communicating with the counselor (Drake & Oetting, 1959).
- Women counselors with a high 0-8 combination may vacillate between conflicts with mother and conflicts with father (Drake & Oetting, 1959).
- Women counselors tend to be nonrelaters and have serious problems, especially when scale 5 is the low point of the pattern (Drake & Oetting, 1959).

Male

Low 1/9 Introverted or self-conscious or socially insecure.

Nothing Low Indecisive, unhappy, worries a great deal, insomnia, confused.

Female

Low 1 Socially shy, shy in the interview, lacks skills with the opposite sex, nonverbal, nervous.

Low 2 Socially shy, shy in the interview, lacks skills with the opposite sex, nonverbal, nervous.

- Note: Scale 2 coded low was infrequently associated with social shyness.

Low 3 Socially shy, shy in the interview, socially insecure, nonverbal, nervous.

Low 4 Socially shy, shy in the interview, nonverbal, nervous.

Low 5 Socially shy, shy in the interview, nonverbal, nervous, anxieties, distractible in study.

Low 6/7/9 Socially shy, shy in the interview, nonverbal, nervous.

Nothing Low Socially shy, shy in the interview, lacks skills with the opposite sex, nonverbal, 8+ conferences, nervous, depressed, father conflict, mother conflict, sibling conflict.

(Drake & Oetting, 1959)

089 Code

Male

Low 1 Introverted or self-conscious or socially insecure.

Low 6 Rationalizes a great deal.

Nothing Low Indecisive, unhappy, worries a great deal, confused, insomnia.

- Note: Scale 9 coded high was infrequently associated with indecisiveness and worrying a great deal.

Female

Low 1 Socially shy (09, 08), shy in the interview, lacks skills with the opposite sex, socially extroverted (9-1), nervous, restless, nonverbal (08), verbal (89), 8+ conferences, resistant in the interview, confused, vague goals.

- Note: Scale 9 coded high was infrequently associated with shyness in the interview.

Low 2 Socially shy (09, 08), shy in the interview, socially extroverted (9-2), nervous, restless, exhaustion, nonverbal (08), verbal (89), 8+ conferences, resistant in the interview, confused.

- Note: Scale 2 coded low was infrequently associated with social shyness and confusion; Scale 9 coded high was infrequently associated with shyness in the interview.

Low 3 Socially shy, shy in the interview, socially insecure, nervous, restless, nonverbal (08), verbal (89), 8+ conferences, resistant in the interview, confused, vague goals.

- Note: Scale 9 coded high was infrequently associated with shyness in the interview.

Low 4 Socially shy, shy in the interview, nervous, restless, nonverbal (08), verbal (89), 8+ conferences, resistant in the interview, nonresponsive, confused.

- Note: Scale 9 coded high was infrequently associated with shyness in the interview.

Low 5 Socially shy, shy in the interview, nervous, restless, anxieties, exhaustion, nonverbal (08, 08-5), verbal (89, 89-5, 9-5), 8+ conferences, resistant in the interview, wants answers, confused, distractible in study.

- Note: Scale 5 coded low was infrequently associated with resistance in the interview; Scale 9 coded high was infrequently associated with shyness in the interview.

Low 6/7 Socially shy, shy in the interview, nervous, restless, nonverbal (08), verbal (89), 8+ conferences, resistant in the interview, confused.

- Note: Scale 9 coded high was infrequently associated with shyness in the interview.

Nothing Low Socially shy, shy in the interview, lacks skills with the opposite sex, nervous, restless, depressed, nonverbal (08, 0-X), verbal (89), 8 + conferences, resistant in the interview, confused, father conflict, mother conflict, sibling conflict.

- Note : Scale 9 coded high was infrequently associated with shyness in the interview.

(Drake & Oetting, 1959)

09/90 Codes

See 90/09 Codes.

Male

Low 1 Introverted or self-conscious or socially insecure.

Low 6 Rationalizes a great deal.

(Drake & Oetting, 1959)

Low 0

Drake found no consistent characteristic in a large number of college counselees with this pattern except that as contrasted with the total group the low 0's tended not to follow through with counseling appointments.

Conspicuously absent from this group were problems relating to indecisiveness, unhappiness, and poor rapport.

(Dahlstrom, Welsh, & Dahlstrom, 1979)

Normal Code, High K

(K+)

The $K+$ profile (Marks et al., 1974) is quite common in outpatient settings among people of upper SES and does not suggest the extent of psychopathology reflected by a similar profile in an inpatient setting. In an inpatient setting, this profile reflects a highly controlled, denying individual whose underlying psychological problems are suppressed. Profiles well within the normal limit range, with a K scale over T -65, are challenging to interpret. In some cases, they reveal a poised, emotionally sophisticated individual who approaches life with a “stiff upper lip.”

The archetype of British reserve and emotional control captures the high K individual. In such cases, suggesting the individual is “defensive” would be unreasonable since their emotional control and reserve may well be due to culture or personality. In other cases, a $K+$ profile may represent an individual who is defensive and masking inner turmoil.

On the basis of the MMPI-2 re-standardization, the following adjustments to the Marks et al. (1974) rules are suggested. Research is needed to support these modifications. In inpatient settings the following criteria should be met: F must be below T -65, L and K must be greater than F , six or more of the clinical scales must be below T -56, and $K - F$ must be greater than five T -score points. This profile often is produced by persons who are highly defensive about admitting psychological problems, which they view as personal weaknesses. Usually, they avoid situations in which their own performance might be compared unfavorably with others and are generally cautious, anxious, and inhibited. They are particularly influenced by others' evaluations of them and, as a result, are easily dominated, led, or controlled. Withdrawn from others, they often are seen as suspicious and fearful, with a strong schizoid component to their personality.

TREATMENT

Whether as an inpatient or outpatient, these individuals need *K*-lowering therapies that help them become aware of their feelings. Once rapport has developed, help them ventilate and role-play, expressing anger, sadness, and even joy, so as to lower their over-control.

THERAPEUTIC FEEDBACK LANGUAGE

Your profile suggests that you are a person who tends not to wear feelings on your sleeve. In a crisis when people are “losing their heads,” you stay cool, calm, and collected. Others may have difficulty “reading” your emotional state. If you are angry, you might express it in a somewhat refined or controlled manner, so others will have to multiply the intensity of what you are saying in order to understand the intensity of your true feelings. Even when you experience surges of positive emotion you may not express them in ways that are obvious to others. Perhaps you grew up in a family that was highly emotional and, at times, emotionally out of control; therefore, you learned to suppress the expression of strong feelings. Perhaps at an early age, you had to stay cool, calm, and collected, because the adults in your life were emotionally volatile. In other cases, people with your personality style grew up in families where emotions were expressed in controlled and refined ways. Practice with your therapist role-playing different emotions so you can become comfortable with spontaneous emotionality. Be aware that others may have a difficult time reading you. When you do experience surges of strong emotion, learn to express your feelings in a manner that allows others to be empathetic toward you.

Content Scales

On the MMPI, the scales were derived empirically (statistically). Questions whose answers differentiated between diagnostic groups were used to form the scales (which were then named after the diagnostic groups). Little consideration was given to scale overlap.

a. the same score can be obtained by individuals who endorse different kinds of information

Content scales were developed to look more specifically at the type of information generated by a specific across the usual clinical scale

General Principles for the Interpretation of Content Scales

Like the Wiggins content scales, scores on the MMPI-2 content scales are highly vulnerable to manipulation. The strong unithematic character of these scales, combined with the generally high obviousness or face validity of the items comprising them, places them at the ready disposal of the respondent in accordance with his or her desires.

This feature is both an asset and a liability for the assessment process. It is an asset in the sense that the homogeneity and obviousness of these scales make them suitable for a handshake across the item pool. Content scales are “user-friendly,” facilitating communication between patient and clinician. Content scales, in effect, unburden the process of self-report and allow the patient greater freedom of movement within the item pool to reveal the kinds of symptoms, concerns, and attitudes considered most salient and problematic. These scales allow the patient to record the kinds of difficulties creating concern, to rank order their severity, and to contrast them with problem areas that have not given rise to concern, presumably those areas experienced by the patient to be conflict free and well within the patient’s sphere of competencies to manage. In other words, the patient’s control of all three features of a profile of scores—elevation, shape, and scatter—is far greater with the content scales than with other scale groupings, such as the standard clinical scales. MMPI/MMPI-2 data at the content level permit, if not encourage, a shared frame of reference between patient and clinician that, if seized by both, defines the assessment process as a collaborative enterprise; engages the trust of and promotes a sense of personal potency on the part of the patient; can be a stimulus to accurate empathy for the therapist; and can lead to a clear sense that the patient is speaking, the clinician is listening, and the two are in a state of communication. The obvious, homogeneous character of the content scales is a liability in the sense that the respondent who wishes to falsify, obscure, or otherwise present an inaccurate or deceptive account of his or her functioning and symptomatology will find few obstacles for doing so. This once again emphasizes the importance of properly preparing the patient for assessment by explaining the process and its purposes, seeking the patient’s cooperation as a collaborator rather than as a subject by exploring ways that testing might help to answer questions of significance to the patient, and otherwise trying to advance the patient’s individual purposes, as well as promising prompt and detailed test feedback. It is when the patient feels deprived of a stake in a collaborative relationship with the clinician and the outcome of the assessment that motivation to mislead the assessor and frustrate the goals of assessment is apt to be highest and the risk of a manipulative and deceptive response style is greatest. The patient wishing to present a distorted picture of adjustment may choose to exaggerate or minimize all manner of problems or may selectively emphasize some areas of difficulty and de-emphasize others. Some patients, typically among the most disturbed, will intentionally exaggerate or minimize some kinds of

problems but inadvertently claim, or fail to claim, symptoms or complaints that disorder severity has placed outside the reach of conscious manipulation. Such cases can enormously confound and frustrate efforts at interpretation.

The extent of the patient's control of elevation in the content scales can create confusion and uncertainty to clinicians accustomed to following the distinction between elevations at or above T-65 and those failing to reach this level. Among the standard clinical scales, the operation of K, the internal corrections for some scales (e.g. Scale 2), and the inclusion of subtle item content for many scales tend to support a line of demarcation between the so-called normal and clinical ranges. The fact that the rate of endorsement for obvious items varies inversely with the endorsement rate for subtle items operates to push T-scores up when an excess of subtle items are endorsed and to decelerate elevations when obvious items are over-endorsed (Burkhart, Christian, & Gynther, 1978). For the content scales, however, these moderating factors are unavailable. As a consequence, content scale elevations are highly vulnerable to differences in response style, and both extremely high-ranging and extremely low-ranging content profiles are commonly seen. Reliance on a particular absolute elevation standard, such as T-65, as an interpretive guideline is much more hazardous in the case of content scale elevations than it is for the standard clinical scales. Instead, the appropriate interpretation of content scales depends much more heavily on relative elevations, regardless of whether the average elevation of these scales is high or low. Because of the extensive shared variation among the content scales, a substantial elevation on a given scale may be required before the variance that is shared with other, similar scales can be assumed to have been exhausted and that fraction of variance unique to the scale in question may be supposed to have "kicked in." The point at which this unique variance can be considered to be in play will vary with both its absolute level of elevation and with its elevation relative to other scales with which it shares variance. For example, consider a male patient obtaining scores of T-92 on both ANX and DEP. At this level, the items on ANX have been exhausted, but five items on DEP were marked in the non-scorable direction. It may, therefore, be tentatively assumed that this pattern of scores reflects the substantial contribution of the variance that the two scales share but a relatively larger fraction of variance that is unique to ANX than that unique to DEP. The clinician would, therefore, be justified in interpreting the ANX score more aggressively than the DEP score, even though the scales are equally elevated. Consider now a female patient with a score of T-69 on ANX and of T-83 on DEP. In this case, eight items from each scale were marked in the non-scorable direction, yet the difference in elevation suggests that these scores reflect the relatively greater contribution of unique variance of DEP than that for ANX. Thus, the clinician could, with some confidence, make the assumption that the DEP score reflects a true depressive phenomenon, whereas the ANX score may indicate no more than the kind of discomfort common to both anxiety and depression, even though ANX is elevated into the "clinical range," and interpreted accordingly. Of course, it is unnecessary for any of the content scales to equal or exceed any particular level in order to be

interpretable, provided that there are sufficient differences in elevation among these scales to suggest the operation of their unique variances.

Similar considerations apply to very-low-ranging content scale scores. In the great majority of cases, such scores result from a defensive approach to the content of the MMPI-2, in which an effort has been made to avoid all responses that might suggest maladjustment or psychopathology, and the clinician will have been alerted to this approach by the configuration of L, F, and K. It is, nevertheless, important to consider how successful the respondent's efforts to avoid the revelation of psychopathology have been and, where a failure to do so is indicated, to attempt identification of possible causes for such failure. For example, consider a case in which all of the content scales except ANG and TPA are below T-40. ANG is at T-43, and TPA is at T-48. Although such a profile suggests that the avoidance of pathological content has been largely realized, the avoidance of items reflecting angry or hostile content was relatively less successful.

If expressions of anger and hostility are less well-contained on the MMPI-2 than other problems, a question may be raised as to whether the control of such expressions in other areas of the respondent's life are also less than fully adequate. It may be that the respondent is comfortable endorsing a few of the ANG and TPA items out of a feeling that his or her ire, when present, is never less than fully justified. In this context, the respondent may feel that his failure to endorse these few items would amount to the admission of something having worse pathological implications: cowardice, tolerance for injustice, intolerable passivity, or a lack of principle. Consider another example, in which content scale scores range from a low of T-30 to a high of T-47, but with BIZ having the highest score. Here, one may ask, given an obvious effort to avoid pathological content, why should failure occur on a scale having such egregious pathological implications. Because it is not unusual for psychotic ideation to underlie errors in judgment, including the kinds of social judgment that may be at play in completing the MMPI-2 (particularly in the context of ego-syntonic delusions), it is reasonable to consider the possibility of psychotic mentation in the search for an answer to this question. The reader may object, noting that a T-score of 47 corresponds to a raw score of only a single item. But, however well-taken, this objection does not address the question of why one of this kind of item was endorsed and not an item with less severe implications. One might also object that a single-item endorsement could be the result of an accident in marking, a distraction, a lapse in attention, a manifestation of fatigue, a temporary misalignment of test booklet and answer sheet. Indeed, these possibilities should be admitted into consideration. But the endorsement of clearly pathological content in the context of a highly defensive test protocol is always worthy of further investigation.

The interpretation of content scale scores can often be enhanced in both clarity and precision by making reference to general moderators of test performance, such as factor scales A and R, and to other gross measures of deviance (e.g. F and F – K), defensiveness (e.g. K), and behavioral dyscontrol (e.g. DISC [Disconstraint]). For example, a person with a score of T-65 on both DEP and K may be much more disabled than a person with a score of T-65 on DEP, and T-45 on K. In the first instance, K may be suppressing the endorsement of items reflecting depression that might otherwise be made. In the same vein, the patient who scores T-70 on BIZ and T-75 on F may be more disabled by psychosis than one who obtains an identical BIZ score but a score of T-90 on F because the higher F score provides BIZ greater “permission” to elevate. In other words, an individual elevating F at T-90 is likely endorsing a wide variety of unusual items but may not be responding preferentially to psychotic content. By contrast, in the context of a BIZ score at T-70, a much lower F elevation would suggest a narrow focus on the psychotic content of F, the content of which may be elaborated from the non-overlapping items on BIZ.

Treatment Planning with the MMPI-2

Content Scales

The MMPI-2 content scales provide a direct assessment of many of the individual’s problems and personal attitudes that require attention in treatment sessions. Elevated scores on these scales provide important clues concerning the focus of therapy since they summarize problems the individual considers important in his or her case.

TABLE 5.6 1 DESCRIPTION OF THE MMPI-2 CONTENT SCALES

<i>ANXIETY</i> (ANX, 23 ITEMS):	High scorers report general symptoms of anxiety, including tension, somatic problems (i.e., heart pounding and shortness of breath), sleep difficulties, worries, and poor concentration. They fear losing their minds, find life a strain, and have difficulties making decisions. They appear to be readily aware of these symptoms and problems and are willing to admit to them.
<i>FEARS</i> (FRS, 23 ITEMS):	A high score indicates an individual with many specific fears. These specific fears can include blood; high places; money; animals such as snakes, mice, or spiders; leaving home; fires, storms, and natural disasters; water; the dark; being indoors; and dirt.
<i>OBSESSIVENESS</i> (OBS, 16 ITEMS):	High scorers have tremendous difficulties making decisions and are likely to ruminate excessively about issues and problems, causing others to become impatient. Having to make changes distresses them, and they may report some compulsive behaviors like counting or saving unimportant things. They are excessive worriers who frequently become overwhelmed by their own thoughts.

DEPRESSION (DEP, 33 ITEMS):	<p>High scores characterize individuals with significant depressive thoughts.</p> <p>They report feeling blue, uncertain about their future, and uninterested in their lives.</p> <p>They are likely to brood, be unhappy, cry easily, and feel hopeless and empty.</p> <p>They may report thoughts of suicide or wishes that they were dead.</p> <p>They may believe that they are condemned or have committed unpardonable sins.</p> <p>Other people may not be viewed as a source of support.</p>
HEALTH CONCERNS (HEA, 36 ITEMS):	<p>Individuals with high scores on HEA report many physical symptoms across several body systems. Included are gastrointestinal symptoms (e.g., constipation, dizziness and fainting spells, paralysis), sensory problems (e.g., poor hearing or eyesight), cardiovascular symptoms (e.g., heart or chest pains), skin problems, pain (e.g., headaches, neck pains), or respiratory troubles (e.g., coughs, hay fever, or asthma).</p> <p>These individuals worry about their health and feel sicker than the average person.</p>
BIZARRE MENTATION (BIZ, 24 ITEMS):	<p>Psychotic thought processes characterize individuals high on the BIZ scale.</p> <p>They may report auditory, visual, or olfactory hallucinations and may recognize that their thoughts are strange or peculiar.</p> <p>Paranoid ideation (e.g., the belief that they are being plotted against or that someone is trying to poison them) may be reported as well.</p> <p>These individuals may feel that they have a special mission or special powers.</p>
ANGER (ANG, 16 ITEMS):	<p>High scores on the ANG scale suggest anger-control problems.</p> <p>These individuals report being irritable, grouchy, impatient, hot-headed, annoyed, and stubborn. They may lose self-control and report having been physically abusive toward people and objects.</p>
CYNICISM (CYN, 23 ITEMS):	<p>Misanthropic beliefs characterize high scorers on CYN. They expect hidden, negative motives behind the acts of others—for example, believing that most people are honest simply for fear of being caught. Other people are to be distrusted, for people use each other and are friendly only for selfish reasons. They likely hold negative attitudes about those close to them, including fellow workers, family, and friends.</p>
ANTISOCIAL PRACTICES (ASP, 22 ITEMS):	<p>In addition to holding similar misanthropic attitudes to high scorers on the CYN scale, high scorers on the ASP scale report problem behaviors during their school years and other antisocial practices like being in trouble with the law, stealing, or shoplifting.</p> <p>They report that they sometimes enjoy the antics of criminals and believe it is all right to get around the law, as long as it is not broken.</p>
TYPE A (TPA, 19 ITEMS):	<p>High scorers on TPA are hard-driving, fast-moving, and work-oriented individuals who frequently become impatient, irritable, and annoyed.</p> <p>They do not like to wait or be interrupted.</p> <p>There is never enough time in a day for them to complete their tasks.</p> <p>They are direct and may be overbearing in their relationships with others.</p>

LOW SELF-ESTEEM (LSE, 24 ITEMS):	<p>High scores on LSE characterize individuals with low opinions of themselves.</p> <p>They do not believe that they are liked by others or that they are important.</p> <p>They hold many negative attitudes about themselves, including beliefs that they are unattractive, awkward, clumsy, useless, and a burden to others.</p> <p>They certainly lack self-confidence and find it hard to accept compliments from others.</p> <p>They may be overwhelmed by all the faults they see in themselves.</p>
SOCIAL DISCOMFORT (SOD, 24 ITEMS):	<p>High scorers are very uneasy around others, preferring to be by themselves.</p> <p>When in social situations, they are likely to sit alone rather than joining in the group.</p> <p>They see themselves as shy and dislike parties and other group events.</p>
FAMILY PROBLEMS (FAM, 25 ITEMS):	<p>Considerable family discord is reported by high scorers on FAM.</p> <p>Their families are described as lacking in love, quarrelsome, and unpleasant.</p> <p>They even may report hating members of their families.</p> <p>Their childhood may be portrayed as abusive, and marriages seen as unhappy and lacking in affection.</p>
NEGATIVE WORK ATTITUDES (WRK, 33 ITEMS):	<p>A high score is indicative of behaviors or attitudes likely to contribute to poor work performance.</p> <p>Some of the problems relate to low self-confidence, concentration difficulties, obsessiveness, tension and pressure, and decision-making problems.</p> <p>Others suggest lack of family support for the career choice, personal questioning of career choice, and negative attitudes toward coworkers.</p>
NEGATIVE TREATMENT INDICATORS (TRT, 26 ITEMS):	<p>High scores indicate individuals with negative attitudes toward doctors and mental health treatment.</p> <p>High scorers do not believe that anyone can understand or help them.</p> <p>They have issues or problems that they are not comfortable discussing with anyone.</p> <p>They may not want to change anything in their lives, nor do they feel that change is possible.</p> <p>They prefer giving up rather than facing a crisis or difficulty.</p>

Internal Symptomatic Behaviors

ANX–Anxiety

- designed to tap into symptoms of anxiety

QUICKNOTES

T-Scores > 65 are indicative of individuals who:

1. feel nervous, worried and apprehensive
2. have problems with concentration
3. complain of sleep disturbance
4. feel uncomfortable making decisions
5. report feeling sad, blue, depressed
6. feel that life is a strain and are pessimistic about life getting better
7. lack self-confidence
8. feel overwhelmed by the responsibilities of life
9. if female, may appear irritable/hostile
10. if psychiatric patients, are likely to have been given anxiety disorder diagnoses

T-Scores > 40 are indicative of individuals who:

1. are not likely to report symptoms of anxiety or depression
2. are decisive and are able to meet the demands of daily life

ANX/Anxiety Generalized anxiety, somatic difficulties, worries, insomnia, ambivalence, tension, a feeling that life is a strain, fear of losing his or her mind, pounding heart and shortness of breath, concentration problems, difficulties making decisions; symptoms clearly perceived and admitted to by the client.

Content and Content Component Scales: *Anxiety (ANX)*

Items: 23; 18 keyed *True*

Major Internal Correlates: Saturated with the First Factor of the MMPI-2, *ANX* is highly correlated with *A*, *RCd*, Scales 7 and 8, *D1*, *D4*, *D5*, *D-O*, *Hy3*, *Hy-O*, *Pd5*, *Sc3*, *Sc4*, *OBS*, *DEP*, *DEP1*, *DEP2*, *WRK*, *TRT*, *NEGE*, *RC7*, *Mt*, *PK*, and *PS*, and negatively with *Es*.

Description: Items reflect generalized anxiety, including excessive worry, nervous tension, disturbed sleep, and problems with attention and

concentration.

Interpretation: A fear of mental collapse that is close to panic. Feeling stressed out and extremely vulnerable to upset by disappointment, financial difficulties, or decisions that don't work out. Dread that a sudden unanticipated event will cause one to "go to pieces."

Positive Aspects: Insight; desire for relief.

Low Scores: Relaxation; nonapprehensiveness.

Most Useful Comparisons: High scores: Scales 7, *OBS*, *DEP*, *DEP1*, *DEP2*, *BIZ*, *LSE*. Low scores: Scales 4, 9, *Pd1*, *Pd2*, *Pd3*, *Pd4*, *Pd5*, *Ma1*, *Ma2*, *Ma3*, *Ma4*, *ASP*, *ASP2*, *AGGR*, *DISC*.

Components: None

Anxiety (ANX)

The *ANX* scale contains 23 items, of which 18 are keyed True, 5 False. Among the MMPI-2 clinical scales, *ANX* correlates most highly with Scale 7 (*Pt*) at .80 and with Welsh's *A* at .80. The primary theme in *ANX* is excessive worry against a background of nervous tension, disturbed sleep, and problems with attention and concentration. Subjective stress levels are already so high that decisions and disappointments are felt to carry the risk of total mental fragmentation and collapse; hence, the anxiety in question in *ANX* is close to panic. High scorers feel "stressed out" and carry a strong sense of both dread and vulnerability. The anxiety in question in *ANX* is also generalized; any and all events are seen as potentially disastrous and devastating, with tensing up and worrying providing the only insulation against the threat that a sudden unanticipated event will cause one to "go to pieces."

The scale has a single item reporting somatic manifestations of anxiety: heart pounding and shortness of breath. Two of the items denote financial concerns. Because the symptoms of anxiety captured on *ANX* tend to pervade conscious experience, they are associated with insight and a strong desire for relief. As a result, patients with high scores will generally have neither the means nor the inclination to conceal these symptoms (although they may feel reluctant to admit other symptoms, such as hallucinations).

Relations to Other Scales

Elevations on other scales in the presence of high *ANX* scores provide a basis for hypotheses about the object of anxiety and the circumstances most likely to provoke a sense of panic. For example, in the presence of an elevation on Bizarre Mentation (*BIZ*), a high *ANX* score may reflect particular concerns about anomalous experience and psychotic disintegration. With a high *LSE* score, a high *ANX* score suggests particular apprehensions around self-devaluation, narcissistic injuries, the imminent withdrawal of dependency supports, and imperiled self-esteem. With a high *DEP* score, a high *ANX* score may suggest fears of a worsening of depressive experience, falling into despair, and a collapse into helplessness and hopelessness.

FRS-Fears

T-Scores > 65 are indicative of individuals who:

1. are fearful and uneasy most of the time
2. report multiple specific fears and phobias

T-Scores < 40 are indicative of individuals who:

1. are not generally fearful
2. do not report multiple fears/phobias

FRS/Fears Multiple specific fears (nuisance animals, blood, dirt, leaving home, natural disasters, mice, snakes, etc.).

Content and Content Component Scales:

Fears (FRS)

Items: 23; 16 keyed *True*

Major Internal Correlates: *Es* and *GM*; both negative correlates.

Description: Items reflect general fearfulness and specific phobias. The word *fear* and its cognates (*afraid*, *dread*, *frightened*) appear in more than three-quarters of the items. The several groups of items include: (a) specific fears of classically phobic type (e.g., darkness, heights, open and closed spaces); (b) animals such as mice, snakes, and spiders; (c)

natural phenomena such as earthquakes, lightning, storms, fire, and water; (d) loss of physical integrity, especially through germs and tissue damage; and (e) admissions of general neurotic fearfulness and a low threshold for feeling fearful that is likely to be incapacitating.

Interpretation: Fearful, apprehensive, easily frightened. High scores suggest displacement/condensation of anxiety onto situations and phobic objects. Not infrequently elevated in defensive paranoid schizophrenia (especially *FRS2*).

Positive Aspects: Harm avoidant; not inclined to take risks; relatively mature defense structure (e.g., avoidance, displacement, condensation).

Low Scores: Intrepid but potentially reckless; judgment may be poor; look for bravado; mania.

Most Useful Comparisons: Scales 1, 6, 7, 9, *Pd2*, *Pa1*, *Pa2*, *Pa3*, *ANX*, *HEA*, *CYN*, *ASP2*, *SOD*, *GM*. With high scores, possible paranoid trends. With low scores, look for indications of fearlessness, recklessness, and poor judgment, such as might be seen in psychopathy or mania.

Fears (FRS)

The *FRS* scale contains 23 items, 16 True, 7 False. It is one of the most independent of the content scales and achieves only modest correlations with a few of the standard MMPI-2 scales. In particular, *FRS* and *ANX* correlate at only .35. *FRS* has no counterpart among the standard clinical scales of the MMPI-2 and shares few items with them. As a result, the presence or absence of phobic symptoms cannot generally be inferred from the standard clinical profile. Excessive fearfulness and more specific phobic concerns form the primary theme of this scale. The word *fear* and its cognates (*afraid*, *dread*, and *frightened*) appear in more than three quarters of the items. The several groups of items include (a) specific fears of classically phobic type (e.g. darkness, heights, and open and closed spaces); (b) animals (e.g. mice, snakes, and spiders); (c) natural phenomena (e.g. earthquakes, lightning, storms, fire, and water); (d) loss of physical integrity, especially through germs and tissue damage; and (e) admissions of general neurotic fearfulness and a low threshold for feeling fearful that is likely to be incapacitating. Ben-Porath and Sherwood (1993) found statistical justification for dividing the scale into two components: *FRS1*, Generalized Fearfulness, and *FRS2*, Multiple Fears.

Components: 2

Generalized Fearfulness *FRS1*

12 items; 11 keyed *True*

FRS1 encompasses most of the items in groups (a), (d), and (e), with a theme of broad apprehensiveness in the approach to daily living, with emphasis on the dangers or potential harmfulness of objects and circumstances in the environment onto which fears can be projected; being easily spooked. Phobic anxiety. Some association with psychoticism.

In terms of the groups of *FRS* items described, *FRS1* encompasses most of the items in Groups a, d, and e, whereas most of the items contained in *FRS2* are from Groups b and c. The theme of *FRS1* is one of a broadly apprehensive tone in one's approach to daily life, one that places an emphasis on the dangers or potential harmfulness of objects and circumstances in the environment. Phobic anxiety appears to be the key empirical correlate of this component (Graham et al., 1999), as well as for *FRS* as a whole. Green, Archer, and Handel (2006), however, report a broader set of correlates for their inpatients based upon Brief Psychiatric Rating Scale (BPRS; Overall & Gorham, 1988), Symptom Check List 90-Revised (SCL-90-R; Derogatis, 1992), and case history data, including excitement, suspiciousness, conceptual disorganization, hallucinatory behavior, unusual thought content, and histories of sexual abuse in addition to the more expectable correlates of anxiety, tension, depressive mood, and somatic concerns. Thus it appears that *FRS1* contains non-negligible, indeed notable, psychoticism variance.

Multiple Fears *FRS2*

10 items; 4 keyed *True*

FRS2 encompasses most of the items in groups (b) and (c). Specific common phobias.

FRS2 contains no theme as such but is simply an enumeration of relatively common phobic objects and circumstances. Low scores on *FRS* connote fearlessness and the risk of reckless disregard for, or obliviousness to, danger, painful consequences or punishment such as may be found in manic-like pictures with euphoria, intrepidity, and poor judgment (high scores on Scale 9 and low scores on Scale 0 and *SOD*), or psychopathic recklessness (high scores on Scale 4, *FAM*, and *ASP* [*ASP* > *CYM*]). Low scores may also be associated with rigid attitudes regarding gender-role requirements in men, particularly macho masculinity (low scores on Scale 5 and high scores on *GM* [*GM* > *GF*]). Occasionally, low scores are seen in the context of "working" somatization pictures, with such physical complaints as abdominal pain, back pain, or visual problems. The meaning of extreme scores on *FRS* is highly dependent on other features of the content and clinical profiles. When elevated with Scale 7, especially the 273/723 profile, *FRS* connotes phobic anxiety. In conjunction with profiles with peaks on *HEA* (and perhaps

Scale 3, *Hy4*, *Sc6*, and *HEA2*), elevations on *FRS* connote a strong harmavoidant orientation and strong fears of somatic injury, illness, or decay.

Relations to Other Scales

Both *ANX* and *FRS* tap phenomena of apprehension. In the case of *ANX*, the apprehension one feels is inchoate; one feels trepidation over the unpredictability of external and internal events that are feared to lead to disorganization and chaos. The defense against this feared breakdown in organization is active in the sense of involving preparation to contend with or absorb the threatened sudden event. With obsessive worry, one has a means of anticipating catastrophe in time to avert or avoid it. In *FRS*, however, the apprehension is condensed onto a particular object or situation, or set thereof; the focus is on the avoidance of injury and harm, and the defense against these dangers is fundamentally passive: one seeks not to contend with the feared object or situation but to avoid it; if unable to avoid, one might freeze or panic. The condensation of apprehension onto known objects and situations enables developmentally more advanced defense mechanisms to be brought to bear in the management of anxiety based on repression and displacement, measures which restore a sense of freedom from fear in those areas of life and functioning that do not risk exposure to phobic foci. This may explain, in part, why the correlation between *FRS* and *ANX* is not greater. In some patients experiencing generalized and incapacitating fear or anxiety, a score greater than *T*-70 on *FRS* or, especially, on *FRS1*, may be operating to mask more serious psychopathology, not excluding active psychosis (check *Sc*, *Sc3*, *BIZ*, *PSYC*, etc.). This is analogous to the familiar relationship between Scales 7 and 8 on the clinical profile in which the degree to which Scale 7 exceeds Scale 8, given the elevation of both scales, reflects the extent of struggle to contain psychotic expressions. In profiles with elevations on both *ANX* and *FRS*, but in which the *FRS* score is higher, the effort to use more mature defensive measures against external and internal threats is suggested, whereas the reverse pattern would suggest a reliance on more primitive defenses. *FRS* is more socially desirable and less negativistic than *ANX*, another indication that it is associated with more mature modes of defensive functioning. Along with Social Discomfort (*SOD*), *FRS* is one of the least socially undesirable among the MMPI-2 content scales. In one type of defensive paranoid patient, *FRS* may stand out as the only elevation of consequence among the content scales and be associated with an especially low Cynicism (*CYM*) score, suggesting a displacement of fears of others onto phobic objects. The patient strongly denies cynical and suspicious attitudes toward others but admits to a greater than average fearfulness of aspects of the nonhuman environment.

C a u t i o n

Familiarity with the component scales for the MMPI-2 content scales, their scores, and their patterns of elevation is essential for making appropriate inferences from their parent scales.

OBS-Obsessiveness

- designed to catch the obsessions in OCD

T-Scores > 65 are indicative of individuals who:

1. show great difficulty making decisions
2. are rigid and dislike change
3. engage in compulsive behavior (i.e. counting / hoarding)
4. fret/worry/ruminate over trivial things
5. may feel dysphoric and despondent and lack interest in things
6. lack self-confidence
7. have intrusive thoughts

T-Scores < 40 are indicative of persons who:

1. do not have difficulty making decisions
2. do not sweat the small stuff
3. can handle changes in their routine

OBS/Obsessiveness Ruminates, difficulty with decision making, resistant to change, needless repetitive counting, may have compulsive behaviors such as counting or alphabetizing his or her experience; worried, sometimes

overwhelmed by his or her own thoughts; others become easily impatient with the person. Persons with low scores are likely to be relaxed, secure, and unlikely to be depressed.

Content and Content Component Scales: *Obsessiveness (OBS)*

Items: 16; all keyed *True*

Major Internal Correlates: Saturated with the First Factor of the MMPI-2, *OBS* is highly correlated with *A*, Scales 7 and 8, *D5*, *Pd5*, *Sc3*, *ANX*, *DEP*, *DEP3*, *LSE*, *LSE1*, *WRK*, *TRT*, *TRT1*, *NEGE*, *RC7*, *Mt*, *PK*, and *PS*, and negatively with *K* and *Es*. Only 5 items overlap with Scale 7.

Description/Interpretation: *OBS* primarily expresses overly busy but massively inefficient cognitive activity. Items reflect indecision and the potentially endless supply of considerations that may be brought to bear in decision making: obsessiveness, worry, intrusive thoughts, preoccupation with detail, timidity and self-doubt, and a fear of taking or committing oneself to concrete, practical action. Only a small minority of items connote classic obsessive-compulsive symptoms apart from obsessiveness as such: 313 (counting), 327 (autogenous obsession), and 547 (hoarding). A ritual item, 193, does not appear on *OBS*.

Although no content component scales were developed for *OBS*, a fairly distinct subset of its items (87, 135, 309, 482, 491, and 509), 38% of *OBS*, reflect indecision/difficulties in decision making. High *OBS* scores when *ANG2*, *TPA1*, or both, are also high may suggest passive-aggressive motivation, with nonperformance via indecision, obsession, and preoccupation with detail being used as a means of coping with the demands and expectations of others and, in turn, engendering responses of impatience, frustration, and exasperation in them.

Low Scores: Suggest an opposite trend, with decisions being made with self-confidence and dispatch, possibly reflecting a histrionic cognitive style (high *Hy-S*). Very low scores may imply overconfidence and a hasty and incautious approach to decision making, such as often is seen in mania (low Scale 2, high Scale 9).

Limitations: The items of *OBS* are ego-dystonic in character and therefore somewhat closer to Obsessive-Compulsive Disorder (OCD) than to Obsessive-Compulsive Personality Disorder (OCPD). Internal consistency strictures employed in developing *OBS* may have prevented it from incorporating the range of content (i.e., content related to symmetry, checking, cleaning, ordering, perfectionism, concerns about contamination, overcontrol, restriction of affect, stinginess, over-conscientiousness, preoccupation with details, and forbidden aggressive, sexual, or sacrilegious thoughts and actions) that would have enabled it to function better as an indicator of OCD symptoms, despite the availability of many potentially suitable items in the MMPI-2 pool (e.g., items 136, 193, 322, 447, 507).

Most Useful Comparisons: Scales 2, 3, 7, 8, and 9, *D4*, *Hy-S*, *Sc3*, *Ma3*, *ANX*, *FRS*, *HEA2*, *ANG2*, and *TPA1*. Scores on these scales may be especially informative when *OBS* is greater than *ANX* and *FRS*. With high scores, look for impaired

cognitive/neuropsychological functioning. With low scores, look for signs of impulsive decision making. It may be that the coincidence of a high point on Scale 7 among the clinical scales and a high point on *OBS* among the content scales may be associated with an increased incidence of OCD, but this has yet to be demonstrated.

Components: None

Obsessiveness (OBS)

The *OBS* scale contains 16 items, all keyed True. It is correlated with *Pt* in the high .70s and with *A* in the low .80s; it shares 5 items with each of these two scales. Although a few of the items do indeed seem classically obsessive in content, the modal item on this scale reflects *indecision*. The main theme, then, is one of overly busy but massively inefficient cognitive activity. Decision making becomes bogged down in detail, but this seems to occur against a background of timidity, if not dread, when faced with the necessity of taking practical action. Low scores on *OBS* suggest an opposite trend, with decisions being made with self-confidence and dispatch. Very low scores may imply overconfidence and a hasty and incautious approach to decision making. At this time, it is unclear what relation, if any, exists between *OBS* and obsessive–compulsive disorder or, especially, obsessive–compulsive personality disorder. An appropriate scale for the identification of these disorders would need to include items having content related to such things as symmetry, checking, cleaning, ordering, perfectionism, concerns about contamination, overcontrol, restriction of affect, stinginess, over-conscientiousness, preoccupation with details, and forbidden aggressive, sexual, or sacrilegious thoughts and actions, as well as with indecision. The content of the MMPI-2 does not include a sufficient number or variety of items in these areas, and not all of those that are included found their way onto *OBS* (see, e.g. *FRS* items 322 and 447). Hence, *OBS* is a good example of a scale for which internal consistency strictures may have prevented the development of a scale having properties that would facilitate detection of obsessive syndromes. Notwithstanding these difficulties, Graham et al. (1999) did find that their high scoring outpatients did manifest “obsessive-compulsive tendencies,” but did not report in what these tendencies consisted.

Relations to Other Scales

To maintain its relevance for the diagnosis of obsessional states and personality styles, it would seem important to require that *OBS* exceed both *ANX* and *FRS* by a margin of $T-10$ to ensure that *OBS* is not being pulled up by the variance it shares in common with the other two scales. (See also discussion of Harkness, McNulty, and Ben-Porath’s (1995) Aggressiveness [*AGG*] and Disconstraint [*DIS*] scales, below.) The negative implications of low *OBS* scores, such as impulsive decision making, are likely to be negligible, or at least not readily apparent, unless low *OBS* scores are accompanied by a low (preferably lower) *FRS* score. Correlations in the .50 to .65 range with measures of anger

and hostility, such as Wiggins' Manifest Hostility (*HOS*), the MMPI-2 Anger (*ANG*), and Type A Behavior (*TPA*), suggest that high *OBS* scores may indicate passiveaggressive motivation (i.e. using nonperformance through indecision, obsession, and preoccupation with detail as a means of coping with the demands and expectations of others and, in turn, engendering responses of impatience, frustration, and exasperation in them).

Caution

Inferences based on *OBS* for Obsessive-Compulsive Disorder, especially Obsessive-Compulsive Personality Disorder, should be made cautiously, if at all, and never in isolation.

DEP-Depression

- designed to catch depressive thoughts

T-Scores > 65 are indicative of individuals who:

1. feel depressed, despondent, sad or blue
2. feel fatigued and lack interest in activities/things
3. are pessimistic and feel hopeless
4. recently have been preoccupied with thoughts of death/suicide
5. cry easily
6. are indecisive and lack confidence
7. feel guilty
8. have a number of health concerns
9. report feeling lonely and empty much of the time
10. are uncertain about their future and find their lives empty and meaningless
11. if female, may be/appear resentful and demanding
12. If psychiatric patients, are likely to have been given depressive disorder diagnoses
12. incarcerated criminals have high DEP scores, but this is probably a situational factor, not a personality factor

T-Scores > 40 are indicative of individuals who:

1. not likely to report symptoms of depression
2. have energy
3. are decisive and confident

DEP/Depression High number of depressive thoughts, uninterested in life; feeling of emptiness; feeling of having committed unpardonable sins; cries easily; unhappy; possible suicidal ideation; sense that other people are not sufficiently supportive; sensitive to rejection, tense, passive feeling of hopelessness; helplessness about the future.

Content and Content Component Scales: *Depression (DEP)*

Items: 33; 28 keyed *True*

Major Internal Correlates: Saturated with the First Factor of the MMPI-2, *DEP* is highly correlated with *A*, *RCd*, Scales 2, 7, and 8, *D4*, *D5*, *D-O Hy3*, *Hy-O*, *Pd5*, *Pd-O*, *Sc1*, *Sc2*, *Sc3*, *Sc4*, *Si3*, *ANX*, *OBS*, *LSE*, *LSE1*, *WRK*, *TRT*, *TRT1*, *NEGE*, *RC2*, *Mt*, *PK*, and *PS*, and negatively with *Es*.

Description: Items reflect brooding, dysphoria, moodiness, apprehension, worry, fatigue, pessimism, loss of interest, self-criticism, irritability, and suicidal ideation, with an emphasis on the cognitive and attitudinal components of depressive syndromes, including helplessness, hopelessness, and worthlessness. Only nine items overlap Scale 2, eight of these on *D5*. Ben-Porath and Sherwood (1993) showed that *DEP1*, *DEP2*, and *DEP3* all reflect aspects of diagnostic criteria for Major Depressive Episode.

Interpretation: High scorers (following the component scales; see below) report despair, a loss of interest, and feelings of fatigue, apathy, and exhaustion (*DEP1*); they are unhappy, blue, and quick to cry (*DEP2*); they show a collapse in self-efficacy and self-regard to the point that they feel guilt-ridden, useless, unpardonably sinful, and condemned (*DEP3*); and they feel hopeless, wish for death, and contemplate suicide (*DEP4*). The empirical correlates of high *DEP* and component scores found by Graham et al. (1999) confirm these features.

Their outpatients often had histories of prior suicide attempts and psychiatric hospitalizations, in addition to profuse depressive symptomatology with hopelessness, suicidal ideation, and disturbed sleep.

Low Scores: Suggest the absence (or denial) of depressiveness rather than the presence of elated or expansive mood, but some low scorers will be seen as defensive, euphoric, irritable, or overactive, especially in psychiatric settings.

Most Useful Comparisons: Scales 2, 7, and 8, *ANX*, *OBS*. Higher Scale 2 than *DEP* suggests greater psychomotor retardation, inhibition of aggression, and vegetative symptoms such as sleep disturbance, anorexia, and weight loss (or gain); higher *DEP* than Scale 2 suggests convictions of worthlessness and futility, along with a view of the self as inadequate or inferior, greater chronicity, and characterologic features.

Components: 4

Lack of Drive DEP1

12 items, 9 keyed *True*

Items report despair; a loss of pleasure, interest, and motivation in living; and lethargy. High scores reflect apathy, anhedonia, an inability to accomplish routine tasks of daily life, and a sense of having given up. Cf. *Sc2* and *Sc4*. Low scores suggest optimism and zest, with active interests, aspirations, and plans for the future.

For *DEP1*: Depressive mood, anxiety, irritability, feelings of hopelessness, trouble concentrating, anhedonia, feelings of worthlessness, thoughts of suicide, and a history of suicide attempts.

Dysphoria DEP2

6 items; 4 keyed *True*

Items reflect dysphoric/depressed mood in the form of subjective unhappiness, especially brooding, feeling sad/blue, and moody spells. Four of the six items overlap *D5* (Brooding). Low scores assert happiness and freedom from the blues.

For *DEP2*, in addition to the correlates above for *DEP1*: Sexual inadequacy, major physical problems, and financial problems as a precipitating factor leading to hospitalization.

Self-Depreciation DEP3

7 items; all keyed *True*

Items reflect self-dissatisfaction, guilt, a sense of moral failure, and a negative self-concept. High scorers admit to feelings of guilt, helplessness, hopelessness, regret/remorse, uselessness, and worthlessness. Cf. *Pd5* and *LSE1*. Low scorers deny such feelings.

For *DEP3*: Depressive mood, guilt, self-blame, and feelings of worthlessness, and sexual inadequacy.

Suicidal Ideation DEP4

5 items; all keyed *True*

DEP4 functions as a critical item list for suicidal ideation and despair, but does not exhaust the supply of such items in the MMPI-2 item pool (see, in addition, items 150, 524, and 530). None of the *DEP4* items appear on Scale 2. Not all are explicitly suicidal in content, but they do imply a level of pessimism about the future that supports a wish to die and thoughts of suicide. As in the case of elevated scores on Scale 2 and/or *DEP*, high scores raise the question of suicide potential and require inquiry into suicidal ideation, past gestures and attempts, and plans. High scores on *DEP4*, in particular, suggest the consideration of active suicide precautions. See also *Hopelessness (Hp)*.

For *DEP4*: Depressive mood, feeling that something bad is going to happen, feelings of hopelessness and worthlessness, thoughts of suicide, death and dying, and a history of suicide attempts.

Depression (DEP)

The *DEP* scale contains 33 items, 28 True, 5 False. Among the MMPI-2 clinical scales, *DEP* correlates most highly with Scale 7 (*Pt*) at .81, and with Welsh's *A* at about .83. Sixteen of its items appear on Wiggins' *DEP*. Six of the items scored on Wiggins' *DEP* now appear on MMPI-2 *ANX*. Although the MMPI-2 and Wiggins' *DEP* scales correlate at about .90, the improved separation between anxious and depressive content in the MMPI-2 content scales suggests that the current *DEP* scale is likely to have somewhat greater specificity and discriminant validity than its Wiggins

predecessor, and considerable evidence for the incremental validity of *DEP* has accumulated (Bagby, Marshall, Basso, Nicholson, Bacchioch, & Miller, 2005; Barthlow, Graham, Ben-Porath, & McNulty, 1999; Ben-Porath, Butcher, & Graham, 1991; Gross, 2002; Gross, Keyes, & Greene, 2000; Hungerford, 2004; Munley, Busby, & Jaynes, 1997; Wetzler, Khadivi, & Moser, 1998).

Ben-Porath and Sherwood (1993) subdivided *DEP* into four components: lack of Drive (*DEP1*), Dysphoria (*DEP2*), Self-Depreciation (*DEP3*), and Suicidal Ideation (*DEP4*). The *DEP1* items report despair and a loss of pleasure, interest, and motivation in life, and correlates with *Sc4*, *D1*, and *D4* at .87, .86, and .86, respectively. High scores reflect apathy, anhedonia, an inability to accomplish even the routine tasks of daily life, and a sense of having given up. By contrast, low scores suggest a zestful approach to daily life in which interests, aspirations, and plans for the future have a solid role. *DEP2* reflects dysphoric/depressed mood in the form of subjective unhappiness, especially a sense of brooding and feeling blue, and of being subject to moody spells. It correlates at .86 with *D1*, and *D5*, with which it shares four of its six items. The *DEP3* items reflect self-dissatisfaction, guilt and sense of moral failure, and a negative self-concept. It correlates with both *Pd5* and *LSE1* at .83. High scorers admit to feelings of guilt, helplessness, hopelessness, regret/remorse, uselessness, and worthlessness. Low scorers deny such feelings. None of the *DEP4* items appear on Scale 2 (*D*). Although not all are explicitly suicidal in content, these items do carry the implication of a pessimism about the future that is so dire as to support a wish to die and thoughts of suicide. High scores raise the question of suicide potential, the need for its assessment, and the probable wisdom of initial precautions against suicidal acts or gestures. As Ben-Porath and Sherwood point out, *DEP1*, *DEP2*, and *DEP3* all lie close to aspects of diagnostic criteria for major depressive episode. *DEP* is highly sensitive to the cognitive and attitudinal components of depressive syndromes. High scorers (following the component scales) report despair and a loss of interest and feelings of fatigue, apathy, and exhaustion (*DEP1*); they are unhappy, blue, and quick to cry (*DEP2*); they show a collapse in self-efficacy and self-regard to the point that they feel guilt-ridden, useless, unpardonably sinful, and condemned (*DEP3*); and they feel hopeless, wish for death, and contemplate suicide (*DEP4*). The empirical correlates of high *DEP* and component scores found by Graham et al. (1999) tend to confirm this description. Their outpatients tended to have histories of prior suicide attempts and psychiatric hospitalizations, and profuse depressive symptomatology, with hopelessness, suicidal ideation, and disturbed sleep. The correlates found by Green et al. (2006), for the *DEP* component scales showed considerable overlap, but the following may be notable.

Although low scores on *DEP* more clearly indicate the absence (or denial) of depressiveness than the presence of

elated or expansive mood, some low scorers will be seen as defensive, euphoric, irritable, or overactive, especially in psychiatric settings.

Relations to Other Scales

DEP overlaps Scale 2 by only nine items, indicating that the two scales are likely to have significantly different patterns of empirical correlates. All of the overlapping items are found on the *D1* subscale (Subjective Depression), and eight of the nine appear on *D5* (Brooding), or 80 percent of that subscale. Convictions of worthlessness and futility, along with a view of the self as inadequate or inferior, are primary in *DEP* but secondary in Scale 2.

Conversely, such syndromal characteristics of depression as psychomotor retardation, the inhibition of aggression, and vegetative symptoms (e.g. sleep disturbance, anorexia, and weight loss making up an important part of Scale 2), are largely absent from *DEP*. The relative elevations of *DEP* and Scale 2, therefore, are helpful in determining both the type and severity of depressive phenomena. To the extent that *DEP* exceeds Scale 2, a chronic condition with predominantly characterological features is suggested. To the extent that Scale 2 exceeds *DEP*, vegetative symptoms and a less complicated symptom picture are characteristic. Bagby et al. (2005) found that *DEP* better distinguished bipolar depression from schizophrenia than Scale 2, and Gross' (2002) findings likewise favored *DEP* over Scale 2 in accurately predicting a diagnosis of major depression. However, Gross et al. (2000) did not find an increase in diagnostic efficiency for *DEP* over Scale 2 in predicting depression.

HEA–Health Concerns

- designed to assess the physical complaints of individuals

T-Scores > 65 are indicative of individuals who:

1. deny good physical health
2. are preoccupied with bodily functioning
3. feel worn out or lack energy
4. report a variety of specific somatic symptoms, including gastrointestinal problems, neurological problems, sensory problems, cardiovascular symptoms, and respiratory problems
5. worry about their health and catching disease
6. feel they are sicker than most people

T-Scores < 40 are indicative of individuals who:

1. claim to be in good physical health and report no specific somatic symptoms
2. do not feel any sicker than other people

HEA/Health Concerns Numerous physical complaints regarding gastrointestinal, neurological, sensory, skin, cardiovascular and/or respiratory difficulties; problems of adjustment; worried and nervous; lacking in energy.

Content and Content Component Scales: *Health Concerns (HEA)*

Items: 36; 14 keyed *True*

Major Internal Correlates: Scales 1, 3, and 8, D3, Hy3, Hy4, Hy-O, Sc6, RC1, and ANX, and negatively with Es.

Description: Items consist of somatic complaints and health worries. Content is strongly redundant with Scale 1 and RC1, with 23 and 20 overlapping items, respectively, and correlating at .95 with each.

Interpretation: High scores reflect concern or preoccupation with health and a tendency to develop physical symptoms in response to stress. Patients may also manifest fatigue, insomnia, nervousness, fearfulness, and characterological features such as pessimism, bitterness, and problems expressing anger.

Low Scores: See discussion of low scores under Scale 1.

Most Useful Comparisons: Scales 1, 3, and 8, *Hy3*, *Hy4*, *Hy-O*, *Sc6*; *ANX* and *DEP* (presence or absence of distress accompanying somatic complaints); *BIZ* (possibility of somatic delusions); and *RC1*.

Health Concerns (HEA)

The *HEA* scale contains 36 items, 14 True, 22 False. The amount of overlap between *HEA* and Scale 1 (*Hs*) is very high at 21 items, more than two thirds of *Hs*. The two scales correlate at $\sim .95$. A majority of the items (20) appeared on Wiggins' Organic Symptoms (*ORG*): 13 on Wiggins' Poor Health. The overlap with *ORG* and the abandonment of most of the genitourinary and lower gastrointestinal items from the MMPI has made *HEA* very different from its Wiggins predecessor. The continuity of content between the two scales is largely limited to items reflecting upper gastrointestinal symptoms and concerns over one's general health status (about five items each). Not surprisingly, in contrast to Wiggins' Poor Health, *HEA* contains many items denoting complaints in and about the head, sensory and motor problems, and a few items reporting losses of consciousness. None of the items in these areas appeared on Wiggins' Poor Health scale. Complaints of pain and other somatic discomfort are more plentiful on MMPI-2 *HEA* than on Wiggins' Poor Health. The greater variety of item content in MMPI-2 *HEA* has been made explicit in the content component scales developed by Ben-Porath and Sherwood (1993). These are: Gastrointestinal Symptoms (*HEA1*), a collection of mostly upper GI items that report nausea, vomiting, stomach pain and discomfort (stomach ache), and constipation. Scale correlates of *HEA1* include *Hy4* at .74 and *D3* at .67. Neurological Symptoms (*HEA2*) covers sensory and motor problems, losses of consciousness, and other head complaints (cf. *Sc6*, with which *HEA2* correlates at .86). General Health Concerns (*HEA3*), the items of which report poor health, and health worries and preoccupations. It correlates with *Hy3*, *D3*, and *Hy4* at .78, .77, and .74, respectively.

The external correlates found for the Graham et al. (1999) outpatients included: For *HEA1*: Somatization, with multiple physical complaints and preoccupation with health problems, depression, and disturbed sleep. For *HEA2*: In addition to those of *HEA1*, developing physical symptoms in response to stress, anxious, pessimistic and overwhelmed, hopeless with suicidal ideation, and having problems in concentration.

For *HEA3*: Somatization, with multiple physical complaints, developing physical symptoms in response to stress, and preoccupation with health problems, and feeling sad, depressed, anxious, pessimistic, hopeless, and overwhelmed and, for women, a history of sexual abuse. The correlates for the Green et al. (2006) inpatients were often similar, as follows.

Components: 3

Gastrointestinal Symptoms HEA1

5 items; 3 keyed *True*

Items report upper gastrointestinal distress, including nausea, vomiting, stomach pain and discomfort (stomachache), and constipation. All items overlap Scale 1.

HEA1: Physical problems as a major problem area, physical illness as a precipitating factor, somatic concerns with nausea and numbness or tingling, and other physical problems, anxiety and depressive mood, and a history of suicide attempts and sexual abuse.

Neurological Symptoms HEA2

12 items; 5 keyed *True*

Items report sensory and motor problems, losses of consciousness, and other head complaints. Two-thirds of the items overlap Scale 1, and half overlap *Hy4* and *Sc6*. When *HEA2* is higher than Scales 2, 8, *HEA*, *HEA1*, and *HEA3*, consider neuropsychological evaluation.

HEA2: Physical problems as a major problem area, physical illness as a precipitating factor, motor retardation, weakness, dizziness, numbness and tingling, hot and cold spells, problems with memory, mind going blank, and symptoms of psychosis (suspiciousness and hallucinatory and/or bizarre behavior) and/or of panic or anxiety (suddenly scared for no reason, heart pounding or racing, checking behavior/ritual checking, trouble sleeping), and a history of suicide attempts.

General Health Concerns HEA3

6 items; 1 keyed *True*

Items report poor health and health worries and preoccupations. Two-thirds of the items overlap Scale 1, 4 overlap *Hy4*, and 5 overlap *D3*.

HEA3: Physical problems as a major problem area, physical illness as a precipitating factor, somatic concerns, feeling that something is wrong with one's body, anxiety, tension and depressive mood, and a history of suicide attempts.

Relations to Other Scales

The characterological features associated with Scale 1 are even more apparent in *HEA*. This is because of the absence of any “dampening” effect of the *K* correction applied to Scale 1. That is, the addition of 0.5 *K* to the raw score for

Scale 1 tends to attenuate its association with measures of dependency, hostility, and other traits. Implications for conflicts around dependency, demandingness and the management of the demands of others, the handling of anger and frustration, and related issues are highly similar for *HEA* and the non-K-corrected version of Scale 1.

BIZ–Bizarre Mentation

- this scale is designed to assess psychotic thought processes

T-Scores > 65 are indicative of individuals who:

1. have psychotic thought processes
2. may report auditory, visual, or olfactory hallucinations
3. may report feelings of unreality
4. feel other people say bad things about them
5. believe others are trying to harm them
6. believe others can read their minds or control their behaviors
7. if psychiatric patients, are likely to have given psychotic diagnoses

T-Scores < 40 are indicative of individuals who:

- report no psychotic processes, hallucinations, delusions, or unreal feelings

BIZ/Bizarre Mentation Psychotic thought processes, hallucinations (auditory, visual, olfactory), paranoid beliefs, strange thoughts, delusions.

Content and Content Component Scales: *Bizarre Mentation (BIZ)*

Items: 23; 22 keyed *True*

Major Internal Correlates: Scales 6, 8, and 9, *D4*, *Pa1*, *Pa-O*, *Sc1*, *Sc3*, *Sc5*, *Sc6*, *Ma-O*, *OBS*, and *PSYC* (with which it overlaps by 14 items), *RC8* (12 overlaps), *RC6* (10 overlaps), and negatively with *Es*.

Description: Items report peculiar and unusual if not delusional ideation, including ideas/delusions of control, persecution, and reference. *BIZ* is the content analogue of the 86/68 profile type. About one-third of the items are paranoid in content. Scores are easily suppressed by intent to appear nonpsychotic. Does not discriminate well between

schizophrenia and other psychotic conditions such as psychotic depression or mania. Content related to resentment is not included (cf. *Pa1* and *Pf1*).

Interpretation: High scorers report being beset by intrusive and disruptive ideas and experiences that they typically attribute to the malevolence of others. They experience a severe loss in the control of their thinking and feel highly vulnerable to being injured or undermined by others' actions.

Low Scores: Reflect the absence (or denial) of these experiences.

Most Useful Comparisons: Scales *F*, *1*, *6*, and *8*, *Pd4*, *ANX*, and *DEP* (presence or absence of distress accompanying psychoticism), *HEA* (possibility of somatic delusions), *LSE* (question of grandiosity when low), and *AGGR*, *DISC*, and *PSYC*, and *RC6* versus *RC8*. *BIZ* is a useful standard for judging the extent to which psychotic content has contributed to elevations on Scales *F*, *6*, *8*, and *PSYC*.

Components: 2

Psychotic Symptomatology BIZ1

11 items; all keyed *True*

Items report frankly psychotic content reflecting positive or accessory symptoms characteristic of schizophrenia and other psychotic conditions (e.g., auditory, visual, or olfactory hallucinations; delusions of persecution and control; and such other first-rank symptoms as thought broadcasting and thought withdrawal). Almost two-thirds of the items refer to paranoid symptomatology, delusions of control in particular (cf. *Pa1*, *RC6*, and *Pf3*).

Schizotypal Characteristics BIZ2

9 items; all keyed *True*

Items are less obviously psychotic in content than *BIZ1* but are nevertheless unusual, odd, peculiar, and weird, such as ideas of reference, derealization, intrusive thoughts, and uncanny sensory experiences as are sometimes seen in prodromal or residual phases of schizophrenia, dissociative conditions, and mood disorders with psychotic features.

Bizarre Mentation (BIZ)

The *BIZ* scale contains 24 items, 23 True, 1 False. Its pattern of overlap with *F* (10 items), Scale 6 (8 items), and Scale 8 (8 items) would suggest that *BIZ* is the content analogue of the 86/68 profile type. About one third of the items are paranoid in content. *BIZ* is a measure of psychotic thought processes. It correlates much more highly with *PSYC* at .90, than with Scale 8 at .58 (Greene, 2011). Both *BIZ* and Scale 8 were able to separate schizophrenia and

major depression in Greenblatt and Davis' (1999) sample of veterans. However, Wetzler et al. (1998) found that although *BIZ* was highly specific (i.e. tended not to elevate in non-schizophrenics, hence a high true negative rate), it lacked sensitivity. It did not separate schizophrenia from major depression in their sample, replicating earlier findings by Ben-Porath et al. (1991) and Munley et al. (1997).

Ben-Porath and Sherwood (1993) divided *BIZ* into two components: Psychotic Symptomatology (*BIZ1*), comprising items with frankly psychotic content reflecting the positive or accessory symptoms characteristic of schizophrenia and other psychotic conditions (such as auditory, visual, or olfactory hallucinations; delusions of persecution and control; and other first-rank symptoms like thought broadcasting and thought withdrawal). Nearly half of these items refer to paranoid symptomatology.

The second component, Schizotypal Characteristics (*BIZ2*), contains items that are less obviously psychotic in content than *BIZ1* but are nevertheless unusual, odd, peculiar, and weird. These include ideas of reference, de-realization, intrusive thoughts, and uncanny sensory experiences such as are sometimes seen in prodromal or residual phases of schizophrenia, dissociative conditions, and mood disorders with psychotic features. The *BIZ1* correlates for the Graham et al. (1999) outpatients included paranoid ideation and symptoms of psychosis, and those for the Green et al. (2006) inpatients were similar, including suspiciousness, unusual thought content, conceptual disorganization, disorientation, and hallucinatory behavior (auditory hallucinations and thought insertion). The correlates for *BIZ2* across these two studies were likewise similar, with Graham et al. reporting anxiety, paranoid ideation, and symptoms of psychosis including loose associations, and a history of prior psychiatric hospitalization, and Green et al. reporting anxiety, alienation, paranoia and suspiciousness, unusual, unpleasant, and/or peculiar thought content, frightening thoughts and images, conceptual disorganization, disorientation, and hallucinatory behavior (auditory hallucinations and thought insertion), expectations of bad events, feelings of deserving punishment, a belief that one's mind is disturbed, and a history of sexual abuse. The *BIZ* items are among the most obvious items on the MMPI-2, so respondents wishing to simulate (malingering) psychosis will be drawn to these items. Conversely, respondents seeking to avoid appearing psychotic on *BIZ* (and on the MMPI-2 more generally) can do so easily, with one important exception. Because insight is often lacking in psychotic conditions, and in schizophrenia in particular, psychotic patients will commonly endorse at least a few of the *BIZ* items even when defensive motivation and guardedness are present. That is, for many patients, their lack of insight renders the psychopathological implications of certain items transparent to them, leading to the endorsement of items that guarded patients whose insight is better preserved would unhesitatingly avoid. For example, a paranoid schizophrenic patient who fears that hospital personnel have been co-opted by his primary persecutors to disable him with medications, and who therefore has every reason to attempt to convince his psychiatric captors that they

have the wrong man, may see no reason not to endorse an item like 162, referencing the idea that one is the victim of another's designs to poison him/her. For this patient, the item may be said to be ego-syntonic, beyond the reach of his motivation to censor test expressions of psychopathology. Thus, high *BIZ* scores, especially when such scores are contributed to by the items of *BIZ1* (even scores above *T*-50 on *BIZ1* should be considered high in defensive profiles), carry implications that are not limited to the content of those items endorsed. Among these are impaired insight, an inability to enter into collaborative relationships, and a grandiose sense of having been selected or appointed for a secret and lofty mission or endowed with special powers. Graham et al. (1999) found relatively frequent histories of physical (men) and sexual (women) abuse among their outpatients with high *BIZ* scores.

Relations to Other Scales

One of the more important uses of *BIZ* is as an index to judge the degree to which psychotic content has contributed to elevations on *F*, Scale 6, and Scale 8. It is not at all uncommon for Scale 8 to exceed *BIZ* by a few standard deviations. Both Scales 6 and 8 have substantial depressive content and may easily elevate in major depression as well as schizophrenia (see, e.g. Bagby et al., 2005). Alienation and lowered self-esteem also may elevate Scale 8 in many different conditions. Reference to *BIZ* in profiles showing elevations on *F*, Scale 6, and Scale 8 can provide valuable guidance in interpretation by emphasizing the importance of psychotic thinking when such an emphasis can be supported by high *BIZ* (especially *BIZ1*) scores and by avoiding such emphasis when it cannot, thereby averting excessively pathological interpretations of Scale 8 elevations. The Low Self-Esteem scale (*LSE*) is very sensitive to the kinds of fixed, negative selfattitudes that often result in high Scale 8 scores. The relative elevations of *BIZ* and *LSE* can thus provide a useful index of the relative contributions of psychotic experience and impaired self-esteem to high scores on Scale 8.

External Aggressive Tendencies

ANG—Anger

- assesses anger control problems

T-Scores > 65 are indicative of individuals who:

1. feel angry and hostile most of the time
2. are seen by others as irritable, grouchy, impatient, and stubborn
3. may feel like swearing and smashing things
4. have temper tantrums
5. may lose control and be physically abusive toward others
6. may express anger in passive, indirect ways

T-Scores < 40 are indicative of individuals who:

1. deny feeling generally angry or hostile
2. claim to not lose control and act abusively

ANG/Anger Difficulties in controlling anger, irritable, impatient, annoyed, stubborn, may swear; episodes of loss of control, possibly breaking objects or actually being physically abusive. Persons scoring low are unlikely to be depressed or have significant family problems.

Content and Content Component Scales: *Anger (ANG)*

Items: 16; 15 keyed *True*

Major Internal Correlates: Scales 7 and 8, *Pd-O*, *Ma-O*, *Si3*, *A*, *ANX*, *OBS*, *DEP*, *TPA*, *TPA1*, *WRK*, *NEGE*, *Mt*, *PK*, and *PS*, and negatively with *K*, *S*, and *S4*.

Description: Items report angry impulses and episodes, which have often been pursued aggressively or secondary to a breakdown of inhibitory emotional or behavioral controls, and which have at times resulted in property destruction, injury to others, or both. Angry feelings are at times reported to be distressing and the violence of their expression inexplicable.

Interpretation: High scorers are irritable and volatile, underregulate crude affect, are intolerant of frustration, issue angry expressions at a high rate, and are prone to angry tirades and destructive outbursts. They have strong needs to discharge their ire, and if they feel constrained by external circumstances from discharging in expansive ways through temper tantrums, bouts of yelling and cursing, and the like, they will do so in more controlled ways through frequent bugging, carping, demanding, imposing, intruding, nagging, and quibbling;

deriding, discrediting, irritating, needling, picking on, ridiculing, shaming, and taunting others; and sadistic teasing and being stubborn.

Most Useful Comparisons: Scales 4, 6, and 8, *Pd4*, *Pa1*, *Sc1*, *Sc5*, *ANX*, *DEP*, *BIZ*, *BIZ1*, *BIZ2*, *TPA*, *TPA1*, *TPA2*, *AGGR*, *DISC*, *PSYC*, and *RC9*. Angry/hostile variance characterizes both *ANG* and *TPA*, but the former is hot whereas the latter is cold. When accompanied by elevations on *TPA* (especially *TPA2*) and on *AGGR*, *ANG* connotes hostile and sadistic, not merely angry, motivation. Concurrent elevations on *ANX* and *DEP*, however, especially when *ANG2* is higher than *ANG1*, *TPA1* is higher than *TPA2*, and *NEGE* is higher than *AGGR*, suggest *ANG* is a component of a general pattern of negative emotionality, and that angry expressions are an occasion for guilt, remorse, and self-criticism. This pattern may be associated with a special risk for dramatic suicide, including provoked homicide and murder-suicide. Low *ANX* and *DEP* when *ANG* is high suggests instrumental aggression and the use of anger, or the threat thereof, to intimidate. When elevated with *BIZ*, especially when *ANG1* is higher than *ANG2* and *BIZ1* is higher than *BIZ2*, the instigation to angry expressions may be psychotic, may appear unprovoked, and, when *Pa1* and *AGGR* are also elevated, may be extremely violent.

Anger (ANG)

The *ANG* scale contains 16 items, 15 True, 1 False. Inexplicably, *ANG* does *not* include items 93, 102, 213, or 372, all of which reference anger/irritability more or less explicitly. It shares only two items with the standard validity and clinical scales of the MMPI-2, fewer than any other of the content scales. Eight of the items overlap Wiggins' *HOS*. *ANG* is concerned with poorly controlled anger (Schill & Wang, 1990). High scorers are irritable and volatile people who under-regulate crude affect, are intolerant of frustration, issue angry expressions at a high rate, and are prone to paroxysmal eruptions in the form of angry tirades and destructive outbursts. They have strong needs to discharge their ire, and if they feel constrained by external circumstances from discharging in expansive ways through temper tantrums, bouts of yelling and cursing, and the like, they will do so in more controlled ways through frequent bugging, nagging, picking, carping, quibbling, belittling, discrediting, deriding, needling, ridiculing, shaming, irritating, taunting, sadistic teasing, demanding, imposing, intruding, and being stubborn. As with *ANX*, high *ANG* scores are associated with a high press for expression. Indeed, Graham et al. (1999) reported that their outpatients with high *ANG* scores were illtempered and had histories of being physically abusive, especially the men. The patients also showed high rates of substance abuse and dependence.

Ben-Porath and Sherwood (1993) divided *ANG* into Explosive Behavior (*ANG1*) and Irritability (*ANG2*). The *ANG1* items emphasize behavior over impulse, and correlates with *AGGR* at .88. The opposite emphasis characterizes *ANG2*. *ANG2* correlates with *TPA1* (Impatience) at .79. This difference could also be conceived as a difference in the severity of anger arousal and dyscontrol between the two components.

Components: 2

Explosive Behavior ANG1

7 items; 6 keyed *True*

Items report explosive and violent episodes that have been directed to both persons and property and have likely resulted in injury and damage; these items are reminiscent of the criteria for *Intermittent Explosive Disorder*. Behavior is emphasized over impulse; the opposite emphasis characterizes *ANG2*. High scorers experience an irresistible need to express and discharge angry feelings through yelling and temper tantrums when such feelings are aroused. That is, they feel unable to control and contain anger when it is present. Low scores on *ANG1* emphasize the denial of undercontrolled violent expressions over the denial of anger per se. That is, low *ANG1* scores connote the assertion of better control rather than an absence of angry emotionality.

High *ANG1* scorers admit to explosive and violent episodes that have been directed to both persons and property and have likely resulted in injury or damage. The items are reminiscent of the criteria for intermittent explosive disorder. The high *ANG1* scoring outpatients studied by Graham et al. (1999) were seen as quite hostile, given to temper outbursts, with the men showing histories of convictions for domestic violence. Both the men and women had long histories of alcohol abuse, with the men showing long histories of marijuana abuse as well. The histories of the men were positive for having been physically abused, and those of women having been sexually abused and for prior suicide attempts and misdemeanor convictions. The Green et al. (2006) inpatients were described as having hostile and destructive urges, and showing antisocial behavior as a major problem area, and histories of alcohol and drug abuse, including as precipitating factors. Low *ANG1* scores emphasize the denial of under-controlled violent *expressions* over the denial of anger per se. That is, the low *ANG1* scorer is more likely to be asserting better control than an absence of angry emotionality.

Irritability ANG2

7 items; all keyed *True*

Items report high levels of anger and irritability, and a quickness to become annoyed, but also a sense of distress and perplexity about these reactions. The emotional tone of *ANG2* is more dysphoric than hostile, which may inhibit the extremity of the behavioral outbursts that characterize high *ANG1* scorers. The combination of anger and inhibition themes in *ANG2* suggests that it may be responsive to partial or attenuated expressions of anger that are emitted within

a context of self-justification, such as argumentativeness, disagreeableness, annoyance, frustration, stalling, pettiness, impatience, complaining, criticism, and passive-aggressive or passive-paranoid maneuvers. Low scores reflect a serene and peaceable temperament.

High *ANG2* scorers admit to a great deal of anger and irritability, but they also experience a sense of perplexity about their reactions and distress over their lack of self-control that may in some degree support the inhibition of behavioral outbursts. The emotional tone of *ANG2* is more dysphoric than hostile. Graham et al. (1999) report that their high scoring *ANG2* outpatients presented as hostile and dysthymic/depressed, and were seen by their therapists as sad, depressed, and self-degrading. The men were also seen as angry, resentful, and anxious, as having suicidal ideation, nightmares and disturbed sleep, many somatic complaints, as developing physical problems in response to stress, and as having family problems and coming from families lacking in love. The women were seen as feeling inferior, coping poorly with stress, and had histories of suicide attempts and prior outpatient treatment. The Green et al. (2006) inpatients were depressed, irritable, and hostile, with destructive urges, unpleasant thoughts, discomfort when observed, somatic concerns, depressive mood, suicide attempts, and sexual inadequacy. They had histories of alcohol and drug abuse, and such abuse was often a precipitating factor. The combination of anger and inhibition themes in *ANG2* suggests that it may be responsive to partial or attenuated expressions of anger that are emitted within a context of self-justification, such as argumentativeness, disagreeableness, annoyance, frustration, stalling, pettiness, impatience, complaining, criticism, and passive-aggressive or passive-paranoid maneuvers.

Evidence for the construct validity of *ANG* has been accumulating. For example, Clark (1994) found an association between *ANG* scores and an anger expression factor among male chronic pain patients. Kawachi, Sparrow, Spiro, Vokonas, and Weiss (1996) reported a significant relationship between *ANG* scores and risk for coronary heart disease (CHD) among older men in the VA Normative Aging Study.

Relations to Other Scales

The *ANG* items and its correlates seem to emphasize the press for discharge over hostile intent in the dynamics of anger, at least as anger is embodied in this scale. High scorers will not infrequently report a sense of being a helpless spectator to their major and minor discharges, viewing with a kind of horror their own destructiveness as they damage property or inflict physical or emotional pain and injury on others, and yet feeling unable to stop themselves. The gratification they report is in the release of anger, not in the damage occasioned by such release. For this reason, individuals scoring high on both *DEP* and *ANG* may be at special risk for dramatic suicide, including provoked homicide and murder-suicide, when they are finally rejected by the partners that they “never meant to

hurt.” This pattern is especially associated with scores on *ANG2*, and the configurations *ANG2* greater than *ANG1*, and *TPA1* greater than *TPA2*. There are important implications of the relationship between *ANG* and its sister scale, *TPA*. The two scales are moderately highly correlated in the high .60s, but whereas the *ANG* theme is “hot,” the *TPA* theme is “cool.” The implication of this difference is taken up in the Type A Behavior scale description.

CYN–Cynicism

- designed to detect the misanthropes among us

T-Scores > 65 are indicative of individuals who:

1. see others as dishonest, selfish, and uncaring
2. are suspicious about the motives of others
3. are guarded and untrusting in relationships
4. may be hostile and overbearing
5. may be demanding of themselves but resent even mild demands placed on them by others
6. do not appear friendly or helpful
7. feel that people use each other and are only friendly for selfish reasons
8. incarcerated criminals have high CYN scores

T-Scores < 40 are indicative of individuals who:

1. express generally positive perceptions of other people
2. are trusting in relationships
3. are not seen as hostile and overbearing
4. are typically friendly and helpful to others

CYN/Cynicism Distrust of other people; fear of being used, or that others will lie and cheat them; belief that the only reason for others not lying or cheating is fear of being caught; negativity toward friends and associates, belief that people are friendly only for selfish reasons. Persons with low scores might be highly achievement oriented.

Content and Content Component Scales: *Cynicism (CYN)*

Items: 23; all keyed *True*

Major Internal Correlates: *Si3*, *ASP*, *ASP1*, *PSYC*, and *RC3* (all positive), and with *K*, *S*, *S1*, *Hy2*, *Hy-S*, and *Pa3* (all negative).

Description: Items appear as points on a dimension extending from naïve altruism and an obtuse absence of skepticism regarding others' motives; through normal prudent regard for one's vulnerability to deceit, mendacity, and chicanery at the hands of others; to the unqualified misanthropic conviction that people are unprincipled and corrupt, invariably acting out of motives that are selfish, perfidious, or craven. Eleven items overlap *CYN1*, 7 overlap *ASP*, all on *ASP1*; and 14 of the items on *S1* and 7 of the items on *Pa3* overlap negatively.

Interpretation: High scorers assert that others are to be distrusted because they act only from self-interest, resort to honesty only to avoid detection, and act friendly only because it makes others easier to exploit. They see life as a jungle in which one must be constantly on the lookout for any competitive advantage because they expect others, given the opportunity, will use any means at their disposal to claim such advantage for themselves. They therefore have no qualms about resorting to deception, hypocrisy, subterfuge, and manipulation to get away with whatever they can. They justify their expedient if not exploitive approach to others with the (projective) rationalization that others are equally selfish, dishonest, and amoral.

Low Scores: Deny normal levels of skepticism regarding the goodwill of others by maintaining that they are completely trustworthy and driven solely by prosocial and altruistic motivations. In so doing, they portray themselves as bastions of benevolence, holders of an unshakable belief in the goodness of their fellow men and women. These sentiments are not infrequently expressed in the context of defensive response styles in which there is some focus on portraying oneself as enjoying consummately harmonious relationships, in which conflict and ill will are unheard of. Cf. *S1* and *Pa3*.

Most Useful Comparisons: For high *CYN* scores, *RC3*, *Pd2*, *Pd4*, *Pa1*, *Pa3* (low), *Sc1*, *Sc3*, *BIZ*, *BIZ1*, *ASP*, *ASP1*, *ASP2*, *LSE*, *PSYC*, and *Re*. These measures permit an estimate of the extent of influence of alienation, antisocial attitudes and conduct, psychotic ideation, or a combination of these, on *CYN*. For low scores: *K*, *S* (esp. *S1*), *Mp*, *Sd*, *Hy2*, *Hy-S*, *Pa3*. These measures permit an evaluation of response style on *CYN* scores and an impression of whether naive, trustful attitudes expressed reflect primarily on the self (*Hy2*) or others (*Pa3*). With low *CYN*, high *LSE/LSE2*, and other indications of dependency (e.g., *Si3*, *Ma4* [low], *Do* [low], *GM* [low]) present, there may be an unusual aversion to giving others offense for fear of rejection or the loss of dependency supports. A peak on *FRS* when *CYN* is low suggests the displacement of fears of others onto phobic objects.

Cynicism (CYN)

The *CYN* scale contains 23 items, all keyed True. Seventeen overlap the Cook and Medley (1954) Hostility scale (*Ho*) with the two scales correlating at $\sim .90$. As a dimension, cynicism covers a broad range of sentiments from naive

altruism, an obtuse absence of skepticism regarding the motives of others, to normal prudent regard for one's vulnerability to deceit, mendacity, and chicanery at the hands of others, to the unqualified misanthropic conviction that people are dishonorable, unprincipled, dishonest, and corrupt, invariably acting out of motives that are selfish, perfidious, venal, or craven. *CYN* models this dimension well, with high scorers asserting that others are to be distrusted because they act only from self-interest, resort to honesty only to avoid detection, and act friendly only because it makes others easier to exploit. They see life as a jungle in which one must be constantly on the look-out for any competitive advantage because they expect others will use any means at their disposal to claim such advantage for themselves, given the opportunity. They therefore have no qualms about resorting to deception, misinformation, hypocrisy, subterfuge, and manipulation to get away with whatever they can. They justify their expedient, if not exploitive, approach to others with the (projective) rationalization that others are equally selfish, dishonest, and amoral. Given its very high correlation with *Ho*, it would be expected that *CYN* would be associated with the increased mortality/morbidity from coronary heart disease found in some investigations of *Ho* (Barefoot, Dahlstrom, & Williams, 1983; Barefoot, Dodge, Peterson, Dahlstrom, & Williams, 1989; Shekelle, Gale, Ostfeld, & Paul, 1983; Williams, Haney, Lee, Kong, Blumenthal, & Whalen, 1980), and indeed Almada, Zonderman, Shekelle, Dyer, Daviglus, Costa, and Stamler (1991) found high *CYN* scores were significantly associated with mortality from coronary illness and from cancer in their large sample of employed men 40 years of age and older.

Low scorers deny normal levels of skepticism regarding the good will of others by maintaining that they are completely trustworthy and driven solely by prosocial and altruistic motivations. At the same time, they portray themselves as bastions of benevolence, holders of an unshakable belief in the goodness of their fellow men and women. These sentiments are not infrequently expressed in the context of defensive response styles in which there is some focus on portraying oneself as enjoying consummately harmonious relationships, relationships in which conflict and ill will are unheard of. In some circumstances, such as when *LSE* and other signs of dependency are high, low *CYN* scores can indicate an unusual aversion to giving others offense for fear that to do so might risk rejection or the loss of dependency supports. Low scores may also be achieved by paranoid defensiveness through the specific denial of paranoid attitudes (e.g. *Pa3* and *Pdf* [paranoid defensiveness; Holroyd, 1964]). Such patients tend to produce highly defensive profiles, typically with *L* and *K* exceeding *F*. The peak among the content scales in this configuration, as mentioned earlier, is often *FRS*, possibly signifying the displacement of fears of others onto phobic objects. Graham et al. (1999) described their high-scoring *CYN* outpatients as hostile and having paranoid ideation, but the men among them were also described as sad and depressed, and as having frequent nightmares and complaints of disturbed sleep. The women had histories of suicide attempts and made broadly negative impressions

on their therapists, who described them as immature, antisocial, insight-less, and unmotivated. In a study of prison inmates, Williams (2002) found significantly greater *CYN* scores among violent than non-violent offenders.

Ben-Porath and Sherwood (1993) divided *CYN* into two components: Misanthropic Beliefs (*CYN1*) and Interpersonal Suspiciousness (*CYN2*).

Components: 2

Misanthropic Beliefs *CYN1*

15 items; all keyed *True*

Items reflect a view of others as deceitful, selfish, untrustworthy, manipulative, unsympathetic, and disloyal. High scorers are likely to be jaded and burned out on relationships with others and unwilling to exert significant efforts to improve them. Low scorers reflect a naive, optimistic, and overly positive view of others.

CYN1 emphasizes a view of others as deceitful, selfish, untrustworthy, manipulative, unsympathetic, and disloyal. Notable scale correlates include *Pa3* at $-.87$, *ASPI* at $.86$, and *Hy2* at $-.83$. High scorers are likely to be “burned out” on relations with others and unwilling to exert significant efforts to improve them. Paranoid ideation was the major correlate among the Graham et al. (1999) outpatients for both *CYN1* and *CYN2*. The *CYN1* men were seen as depressed, having many nightmares, and as ruminative and socially awkward, while their women were seen as more difficult—immature, antisocial, having poor insight and a negative attitude toward treatment, lacking reliability as informants, and being difficult to motivate—as communicating poorly, having narrow interests, and lacking an orientation to work and achievement. These women failed to make a favorable first impression and were viewed as not very likable. The Green et al. (2006) inpatients showed hallucinatory behavior.

Interpersonal Suspiciousness *CYN2*

8 items; all keyed *True*

More dysphoric than *CYN1*, these items reflect a theme of feeling oneself to be a particular target of others’ cynical, hostile, manipulative, or exploitive actions leading to suspicious and guarded reactions. High scorers feel under fire and vulnerable to others, especially superiors, who are thought to be stingy with recognition and understanding and to be trying to disadvantage them. Low scores reflect excessive self-confidence and a conviction that their

relationships with others are marked by unusual harmony, mutual understanding, and an absence of competitiveness.

CYN2 emphasizes similar sentiments but includes a theme of feeling oneself to be a particular target of others cynical, hostile, manipulative, or exploitive actions, leading to suspicious and guarded reactions. It therefore has a more dysphoric tone than *CYN1*. The Graham et al. (1999) outpatient men were seen as dysthymic/depressed, and had histories of few or no friends, while the women were seen as undependable and lacking in insight. The Green et al. (2006) inpatients showed conceptual disorganization and hallucinatory behavior, and had histories of sexual abuse. The high *CYN2* scorer feels “under fire” and vulnerable to others, especially superiors, who are felt to be stingy with recognition and understanding, and who are trying to disadvantage him or her.

Relations to Other Scales

Butcher et al. (1990) found rather different empirical correlates for men and women on *CYN*. The re-standardization men were rated as having temper tantrums, whining, demanding, nagging, and lying but also as lacking an interest in things. The women were rated as less hostile but more psychologically disturbed. They were described as suspicious, nervous and jittery, preoccupied with death/dying, apathetic, and showing poor judgment. The pattern suggests either that among women, cynicism is more damaging to psychological functioning or that elevated *CYN* scores may be a consequence of more general or severe psychological disturbance. For men, in contrast, elevations on *CYN* appear to reflect a more specific trait disturbance that is more localized to interpersonal relations. For either gender, *CYN* is likely to interact with measures of dependency (e.g. *Si3* [Self-Other Alienation], *Do* (Dominance) [low], *GM* [low], *LSE*, and *LSE2*) and, where both are high, to signify higher levels of stress and discomfort in interpersonal functioning. Dependent high *CYN* scorers are in the position of being unable to trust those on whom they depend, and are therefore vulnerable to rapidly fluctuating levels of comfort as their psychological distance from significant others waxes and wanes. Too close and they feel the threat of engulfment and of losing autonomy; too distant and they feel vulnerable to abandonment, isolation, and loss.

As would be expected, when concurrently elevated with *ASP* and/or *BIZ*, the manifestations of high scores on *CYN* may be substantially augmented in terms of their offensiveness in the case of *CYN* with *ASP*, such as might be seen in aggressive psychopathy, or their severity in the case of *CYN* with *BIZ*, such as is not uncommon in paranoid schizophrenia.

ASP–Antisocial Practices

- assesses problematic behaviors, especially in school

T-Scores > 65 are indicative of individuals who:

1. are likely to be in trouble in school or with the law
2. believe that there is nothing wrong with getting around the laws as long as the laws are not broken (or they are not caught)
3. incarcerated criminals tend to have high ASP scores
4. enjoy hearing about the escapades of criminals
5. have a generally cynical attitude toward others
6. resent authority
7. if male, they may express anger and hostility by swearing and having temper tantrums
8. if female, may express anger and hostility less directly
9. If female, may be seen by others as more dishonest, inconsiderate, and not helpful
10. report stealing things, other problem behaviors, and antisocial practices during their school years

T-Scores < 40 are indicative of individuals who:

1. have no trouble in school or with the law
2. are not particularly resentful of authority

ASP/Antisocial Practices Past legal and/or academic problem behaviors; expectation that others will lie, support of illegal behavior; enjoyment of criminal behavior of others; thought patterns that characterize criminal behavior, whether such behavior actually occurs or not. ASP has been found to be a better predictor (greater sensitivity and specificity) of antisocial personality disorder than *Pd* (Psychopathic deviance; S. Smith, Hilsenroth, Castlebury, & Durham, 1999) with a recommended cutoff of 55 or 60 (rather than the suggested cutoff of 65 implied by the MMPI-2).

Content and Content Component Scales: *Antisocial Practices (ASP)*

Items: 22; 21 keyed *True*

Major Internal Correlates: Scales 4 and 9, *Ma-O*, *Si3*, *DISC*, and negatively with *K*, *S*, *Hy2*, *Hy-S*, *Pa3*, *RC4*, and *Re*.

Description: Items reflect cynicism and insensitivity toward the motives and feelings of others; sympathy with violations and violators of established order, rules, and social conventions; and admissions of past rule breaking and trouble with authorities. Antisocial Practices is a misnomer because the items referring to actual misbehavior, all on *ASP2*, amount to less than one-quarter of the items on the full *ASP* scale. Moreover, the two components are only weakly correlated (at .34), and the correlation between *ASP* and its components ($ASP \cdot ASP1 = .95$; $ASP \cdot ASP2 = .63$) is divergent; thus *ASP* is better thought of as an antisocial attitudes scale. Nevertheless, Graham et al. (1999) found that their high *ASP* outpatients frequently manifested antisocial features, including histories of arrest, hostility, antisocial behavior, acting out, low frustration tolerance, substance abuse, and physical abusiveness. Seven items overlap *CYN*, all on *CYN1*.

Interpretation: High scorers subscribe to a wide range of antisocial attitudes and dispositions, are cynical about and rebellious toward conventional behavioral standards, and admit past delinquency and conflicts with authority. Low scorers assert the opposite pattern of beliefs and behaviors.

Most Useful Comparisons: Scales 4, 6, and 9, *Pd1*, *Pd2*, *Pd3*, *Pd4*, *Pd5*, *Pa1*, *Pa3* (low), *Sc1*, *Sc5*, *Ma1*, *Ma2*, *Ma3*, *Ma4*, *ANX*, *FRS*, *OBS*, *DEP*, *ANG1*, *CYN*, *CYN1*, *CYN2*, *RC4*, *AGGR*, *DISC*, *PSYC*, *R*, *Re*. Examination of the configuration of *CYN* and *ASP*, *CYN1* and *ASP1*, and *CYN2* and *ASP2* permits fairly detailed inferences about individual sentiments and dynamics and may be especially useful in interpreting the 46/64 codetype and its variants (462, 468, 469). *ASP*, *ASP1*, *CYN*, *CYN1*, and *CYN2* are all correlated in a range of .50 to .62 with *Pa1*, suggesting potential paranoid trends given high scores on these scales. $CYN > ASP$, $CYN2 > CYN1$, $ASP1 > ASP2$, and especially $CYN1 > ASP1$, suggest a predominance of paranoid over antisocial features, especially when *ASP2* and *DISC* are low. The opposite pattern suggests the predominance of antisocial trends. Elevations on *ANX*, *FRS*, *OBS*, *DEP*, or a combination of these may reflect the presence (when high) or absence (when low) of distress over antisocial attitudes/conduct. Scores on *Sc5*, *ANG1*, *TPA2*, *R*, *DISC*, and *AGGR* may help refine inferences regarding control and aggression/sadism.

Components: 2

Antisocial Attitudes *ASP1*

16 items; all keyed *True*

Items reflect the belief that most people lie and cheat to get ahead in life, steal because others tempt them, and resort to honesty chiefly to avoid trouble. High scorers endorse a code of silence with authorities, a disdain for the rule of law, a willingness to steal given the opportunity, sympathy for those who treat others rapaciously, and a kind of vengeful joy when others are "catching it." There is thus a strong implicit theme of amorality and defective empathy in this set of items and a tertiary theme of generalized rage at others. Cf. *Ma1*. Low scores reflect an unusually if not naively

favorable view of others' honesty, altruism, and good will, and a view of the self as honest, trusting, friendly, agreeable, responsible, and nonaggressive.

Antisocial Behavior ASP2

5 items; 4 keyed *True*

Items report a history of delinquency, including theft, truancy, school suspensions, and conflict with school and legal authorities. Reflects historic behavioral features consistent with *Antisocial Personality Disorder*. Cf. *Pd2*, *RC4*, and *DISC*.

Antisocial Practices (ASP)

The *ASP* scale contains 22 items, 21 True, 1 False. It shares 3 items with *Pd2* (Authority Problems) and 6 with *CYN1*. The latter items assert that "most people" lie and cheat to get ahead in life, steal because others tempt them, and resort to honesty chiefly to avoid trouble. These and 10 additional items form Ben-Porath and Sherwood's (1993) first *ASP* component, Antisocial Attitudes (*ASP1*). The additional items endorse a code of silence with authorities, a disdain for the rule of law, a willingness to steal given the opportunity, sympathy for those who treat others rapaciously, and a kind of vengeful joy when others are "catching it." There is thus a strong implicit theme of defective empathy in this set of items and perhaps a tertiary theme of generalized rage at others. The Graham et al. (1999) outpatients presented as hostile, but their other correlates showed significant gender differences, with the men showing poor judgment and being intolerant of frustration, having nightmares, with histories of few or no friends, while the women showed a much broader pattern of disturbance, with correlates including hallucinations and suicide attempts, antisocial/sociopathic, immature and undependable, unable to see their own limitations, having superficial relationships, being defensive, difficult to motivate, lacking insight and reliability as informants, and being unlikable. Although the data presented in Graham et al. (1999) do not implicate paranoid ideation among their high-scoring *ASP1* outpatients, the relatively high correlations between *ANG1* and *CYN2* ($-.60$) and *Pa1* ($\sim .50$) do suggest such trends. The correlates found for the Green et al. (2006) inpatients emphasized substance abuse, including as a precipitating factor, and a history of legal charges and incarcerations. The five-item second component, Antisocial Practices (*ASP2*), consists of admissions of past delinquencies, including theft, truancy, school suspensions, and conflict with school and legal authorities. It correlates with *Pd2* at $.71$, and with *DISC* at $.64$. The Graham et al. (1999) outpatient correlates emphasized elements of the antisocial personality pattern, including aggression, anger/temper tantrums, hostility, resentment, impulsiveness, intolerance of frustration, stormy interpersonal relationships, polysubstance abuse, misdemeanor convictions, and multiple arrests. Additionally, their men were seen as suspicious and had histories of felony convictions, including for domestic violence, were self-

indulgent and physically abusive, while their women were described as agitated, argumentative, manipulative, critical, narcissistic, paranoid, defensive and deceptive, and as having family problems and many nightmares. The Green et al. (2006) inpatients likewise had histories of legal charges and incarcerations, but their problems appeared more narrowly focused on alcohol and drug abuse, including as precipitating factors. They also showed a history of suicide attempts. The imbalance in the length of the two *ASP* components is such that the full scale name is something of a misnomer because those items dealing with actual misbehavior (*ASP2*) come to only about one fourth of the full *ASP* scale. Moreover, *ASP2* is comparatively weakly associated with *ASP1* (about .30), a further indication that the relation of *ASP1*, and, to a lesser extent, *ASP* as a whole, to actual antisocial conduct is a tenuous one. Nevertheless, as compared with Scale 4 (*Pa*), Smith, Hilsenroth, Castlebury, and Durham (1999) found that *ASP*, but not Scale 4, was significantly correlated to DSM-IV diagnostic criteria for Antisocial Personality Disorder (APD), and was able to differentiate APD from other personality disorders. Similarly, Lilienfeld (1996) reported a stronger association for *ASP* than Scale 4 with measures of Machiavellianism and interviewer-rated dishonesty, and incremental validity over Scale 4 for global indexes of psychopathy and antisocial behavior. In the case of high scores on *ASP2* these features were especially pronounced, with multiple arrests, felony convictions, hostility, resentment, impulsiveness, poor frustration tolerance, temper outbursts, domestic violence, stormy and physically abusive interpersonal relationships, and diagnoses of antisocial personality disorder and substance abuse. These features were most commonly present in men but were also represented among their women outpatients, who also had histories of physical and sexual abuse, heroin abuse, family problems, and paranoid features. Williams (2002) found significantly greater *ASP* scores among prisoners convicted of violent offenses than among the non-violent offenders (see also *CYN*, above). In a study of parenting behaviors among low-income women, Bosquet and Egeland (2000) reported an association between *ASP* and parenting styles that were less understanding and more harsh and hostile.

Relations to Other Scales

The most important relative of *ASP* is *CYN*. Examination of the configuration of *CYN* versus *ASP*, *CYN1* versus *ASP1* (note the similarity of the Graham et al. [1999] correlates for these two components for their women outpatients), and *CYN2* versus *ASP2* permit fairly detailed inferences about individual sentiments and dynamics, and may be especially useful in the interpretation of the 46/64 code patterns and its variants (462, 468, and 469). For all three comparisons, a positive slope (i.e. $CYN < ASP$, $CYN1 < ASP1$, and $CYN2 < ASP2$) favors a psychopathic over a paranoid bias, whereas a negative slope favors the opposite bias. The within-scale configurations (e.g. $CYN2 > CYN1$) also may help to guide interpretive efforts when dealing with these issues.

TPA–Type A

- assesses the characteristically Type-A behaviors

T-Scores > 65 are indicative of individuals who:

1. are hard driving, fast moving, and work-oriented
2. never feel they have enough time to get things done
3. do not like to wait or be interrupted
4. are frequently hostile, irritable, and easily annoyed
5. tend to be overbearing and critical in relationships
6. tend to hold grudges and want to get even
7. if female, tend to be restless, tense, and suspicious

T-Scores < 40 are indicative of individuals who:

1. are not particularly competitive, driven, or fast moving
2. do not feel a great time pressure in getting things done
3. are not seen by others as being critical or easily annoyed

TPA/Type A Driven, hardworking, competitive, hostile, irritable with time constraints, overbearing, annoyed with interruptions, tries to do more and more in less and less time, blunt and direct, petty regarding minor details (this scale is a better construct for use with males than females).

Content and Content Component Scales: *Type A (TPA)*

Items: 19; all keyed *True*

Major Internal Correlates: Scales *A*, 7, 8, and 9, *Pd-O*, *Ma-O*, *Si3*, *ANX*, *OBS*, *ANG*, *ANG1*, *ANG2*, *CYN1*, *CYN2*, *ASP1*, *FAM1*, *WRK*, *PSYC*, *NEGE*, *PK*, *PS*, and negatively with *K*, *S*, *Hy2*, *Hy-S*, and *Re*.

Description: The concept of the Type A or coronary-prone personality has been described in the Jenkins Activity Survey (JAS; Jenkins, Rosenman, & Friedman, 1967) as comprising three components: Speed and Impatience, Job Involvement, and Hard-Driving Competitiveness. The first focused on the time-urgency aspect of the Type A syndrome, the second on the extent of occupational demands and the person's dedication or determination to meet or exceed them, and the third on a serious, competitive, and hard-driving self-concept. The items of the *TPA* scale fail to cover this domain adequately, for reasons discussed in Friedman et al. (2001).

Briefly, although the first component may receive a rough approximation in MMPI-2 items (i.e., *TPA1*), the second is represented by, at most, 2 items (507, 531), and the third is saturated with hostility at the expense of its intended themes of competitiveness, and self-imposed demands for performance. The only correlate found among both the male and female outpatients studied by Graham et al. (1999) to be associated with high *TPA* scores was interpersonal hostility. Both *TPA1* and *TPA2* reflect angry emotionality; in *TPA1*, the anger is hot and closer to the irritable-angry emotionality of *ANG*, whereas in *TPA2* it is cold and more calculating, controlled, hostile, vengeful, and sadistic than in *ANG*. Because *TPA2* is the larger of the two components, containing half again as many items as *TPA1*, the quality of *TPA2* is imparted to the full *TPA* scale, making it cooler than the full *ANG* scale.

Interpretation: High scorers have a low threshold for experiencing hostility and vengeful feelings. They are self-centered, resentful, irritable, suspicious, spiteful, and lacking in empathy. They tend to treat others in a cold and dismissive fashion, as necessary evils at best or, perhaps more typically, as obstructionist nuisances, and may take pleasure in their pain and misfortune.

Most Useful Comparisons: Scales *A*, *Ma-O*, *Si3*, *OBS*, *ANG*, *ANG1*, *ANG2*, *CYN*, *CYN2*, *ASP*, *ASP1*, *ASP2*, *WRK*, *NEGE*, 4, 6, and 9, *Ma-O*, *Si3*, *ANX*, *OBS*, *ANG*, *ANG1*, *ANG2*, *CYN1*, *CYN2*, *AGGR*, *DISC*, *RC9*, and negatively with *K*, *S*, *Hy2*, *Hy-S*, and *Re*.

Scores on these scales help to refine inferences for high *TPA* scores, particularly with respect to whether they may be driven by anxiety, perfectionism, cynicism, mistrust, overarousal/hyperactivity, or sadistic aggression, and whether vengeance is likely to be confined to fantasy or acted out aggressively. Note the level of *Pa3*. The Type A behavior pattern appears more likely when *TPA1* > *TPA2*, *CYN* > *ASP*, *CYN* > *TPA2*, *CYN1* > *CYN2*, *CYN1* > *TPA2*, and *WRK* < T-60, than when these relationships do not obtain (Friedman et al., 2001).

The *TPA* scale contains 19 items, all keyed True. Three overlap *ANG*, 1 on *ANG1* and 2 on *ANG2*. Nine of the *TPA* items overlap Wiggins' *HOS*, and 6 items overlap the Cook and Medley (1954) *Ho* scale (*TPA* x *Ho*: $r = \sim .75$). The concept of the Type A or coronary-prone personality as operationalized in the Jenkins Activity Survey (JAS; Jenkins, Rosenman, & Friedman, 1967) included three components: Speed and Impatience, Job Involvement, and Hard Driving Competitiveness. The first focused on the time urgency aspect of the Type A syndrome; the second with the extent of occupational demands and the person's dedication or determination to meet or exceed them; and the third with a serious, competitive, and hard-driving self-concept. The items of *TPA* fail to adequately cover this domain. First, the Job Involvement component is insufficiently represented with, at most, two items (507 and 531). Second, the Hard Driving Competitiveness component is so heavily biased toward hostility that the themes of hostile competitiveness and self-imposed demands for performance tend to recede into the background. Indeed, the only correlate found among both the male and female outpatients studied by Graham et al. (1999) to be associated with high *TPA* scores was interpersonal hostility. In a report from the VA Normative Aging Study, Kawachi et al. (1998) found moderate to poor correlations between the *TPA* and JAS total (.36), Speed and Impatience (.46), Job Involvement (.12), and Hard Driving Competitiveness (.22) scores. However, they did find that *TPA* scores were associated with events related to CHD in a community-dwelling sample of older (mean age = 61 years) men. It should also be noted that the JAS was not related to the risk of CHD in a similar cohort (Kawachi et al., 1998).

Ben-Porath and Sherwood (1993) divided *TPA* into Impatience (*TPA1*) and Competitiveness (*TPA2*) components.

Components: 2

Impatience *TPA1*

6 items; all keyed *True*

Items reflect a sense of time urgency along with delay-stimulated irritability, such that having to wait in line, being interrupted, or having people upon whom one depends fail to do their work on time stirs one to annoyance if not anger. Cf. *ANG2*.

The *TPA1* items convey a sense of time urgency along with delay-stimulated irritability, such that having to wait in line, being interrupted, or having people on whom one depends fail to do their work on time stirs one to annoyance, if not anger. *TPA1* correlates at .79 with *ANG2*. The Graham et al. (1999) outpatient correlates included high levels of hostility and developing physical symptoms in response to stress. An additional correlate for men was the display of unusual gestures at intake. The correlates for women included depression, nervousness, and worry, complaints of somatic symptoms, oversensitivity to criticism, coping poorly with stress, and being histrionic, agitated, restless, grouchy, insecure, self-degrading, socially awkward, and giving up easily. The correlates found for the Green et al.

(2006) inpatients were anxiety, depressive mood, somatic concerns, and histories of sexual abuse, alcohol abuse, and suicide attempts.

Competitive Drive TPA2

9 items; all keyed *True*

Items convey less a spirit of competitiveness than of resentment, vengefulness, and sadism. Two additional items appear thematically displaced from *TPA1* (510, 545), and a third refers to job overinvolvement (531). High scorers admit to wanting to win a point against or pay back people who oppose them, opposing people for trivial reasons, relishing the misfortunes of people whom they dislike, resentment when they feel taken in, and gloating over their competitive advantages.

Cf. *AGGR*.

The *TPA2* items convey less a spirit of competitiveness than of resentment, vengefulness, and sadism. High *TPA2* scorers admit to wanting to “win a point” against or pay back people who oppose them, opposing people for trivial reasons, relishing the misfortunes of people whom they dislike, feeling resentment when they feel taken in, and gloating over their competitive advantages. Two additional items appear thematically displaced from *TPA1* (510 and 545), and a third refers to job overinvolvement (531). *TPA2* correlates with *Ho* at .72. Graham et al. (1999) found only paranoid ideation as a general *TPA2* correlate among their outpatients, though their women were additionally described as immature and having problems with authority figures, while the Green et al. (2006) inpatients showed a history of substance abuse.

Although both components carry themes of angry emotionality, the theme of *TPA1* is “hot” and closer to the irritable-angry emotionality of *ANG*, whereas *TPA2* is “cool” and more calculating, controlled, hostile, vengeful, and sadistic than *ANG*. Because *TPA2* is the larger of the two components, containing half again as many items as *TPA1*, the quality of *TPA2* is imparted to the full *TPA* scale, making it “cooler” than the full *ANG* scale.

The question may be raised as to whether *TPA* can be presumed to be a construct valid measure of the Type A syndrome. Although there can be little doubt that the scale has *some* construct valid variance if the JAS is held as the standard, it appears on the basis of the limitations of *TPA* as a measure of Type A Behavior described earlier, and from the lack of supportive construct-related evidence from empirical investigations, that *TPA* is unlikely to function as a sufficiently sensitive and specific measure to support construct-relevant predictions in the individual case. It may be possible, however, on rational grounds, to develop a configurally-based indicator involving scores on *TPA*, its

components, and other scales in a way that would combine relevant sources of variance to maximize the success of predictions of Type A Behavior. A group of hypotheses for this purpose follows.

Relations to Other Scales

Because of the overlap of three items between *TPA* and *ANG*, as well as the similarity of the content between *ANG2* and *TPA1*, these two scales must be distinguished more extensively. As noted already, *ANG* is the “hotter” of the two, and *TPA* the “cooler.” That is, there is a more urgent press for the expression of affect in *ANG* than in *TPA*. The high *TPA* scorer is better controlled, more deliberate, more rigid, and less impulsive than the *ANG* scorer at comparable elevations. The high *TPA* scorer is also less dysphoric, less anhedonic, and less inclined to avoid or deny evidence of personal error or shortcomings than his or her high *ANG* counterpart. That is, *TPA* is thematically more grandiose and narcissistic than *ANG*. It is also more cynical, suspicious, self-justifying, disdainful, and control avoidant than *ANG*. Although the high *ANG* scorer is more irritable, angry, and volatile than the high *TPA* scorer, his or her enmity toward others is less persistently sadistic and domineering; it involves a lesser determination to control and inflict emotional injury on others. The greater control inherent in *TPA* is sufficient to create an impression of assertiveness at times when a comparable *ANG* score would create an impression of excessive anger.

As noted previously, one of the chief weaknesses of *TPA* is the lack of item content related to job involvement. The Work Interference scale (*WRK*) does contain content that can be considered to be at least indirectly related to this aspect of the Type A construct. Of the 33 items on *WRK*, 13 (39 percent) contain the word *work* or one of its cognates (e.g. job). The content of *WRK* includes many items having clear relevance to job involvement and other components of the Type A construct, including eagerness or enthusiasm for work, concentration at work, self-confidence at work, perseverance, competitiveness, and coping with obstacles to work. Of these *WRK* items, about 8 are consistent with one or more of the JAS themes when endorsed in a manner consistent with the *WRK* key, and about 21 are consistent with the items on the JAS when scored in the direction opposite to those on *WRK*. With this pattern in mind, it can be hypothesized that the sign value of high *TPA* scores for the Type A Behavior pattern may be enhanced when *WRK* scores fall below *T*-60. Given the extremity of the hostile implications of *TPA2*, it is likely that the Type A Behavior pattern is more strongly suggested when scores on *TPA1* exceed those on *TPA2* than vice versa. Finally, given the high overlap between the *CYN* and *Ho* scales, which has been independently (of the JAS) shown to contain variance for coronary morbidity/mortality, *CYN* scores may support the inference of Type A dynamics when *CYN* exceeds *ASP* and when *CYN1* exceeds *CYN2*. *CYN* and *CYN1* scores that exceed *TPA2* scores might also have incremental value in identifying the Type A pattern.

Negative Self-View

LSE—Low Self-Esteem

- assesses the client's opinion of himself/herself

T-Scores > 65 are indicative of individuals who:

1. have poor self-concept
2. anticipate failure and give up easily
3. are oversensitive to criticism and rejection
4. have difficulty accepting compliments
5. are passive in relationships
6. have difficulties making decisions
7. have many worries and fears

T-Scores < 40 are indicative of individuals who:

1. are self-confident and expect to succeed
2. are decisive
3. are not sensitive to criticism or rejection
4. do not report worries or fears

Content and Content Component Scales: *Low Self-Esteem (LSE)*

Items: 24; 21 keyed *True*

Major Internal Correlates: Scales A, 7, 8, and 0, D1, D4, D5, D-O, Pd5, Pd-O, Sc1, Sc4, Si3, ANX, OBS, DEP1, DEP3, WRK, NEGE, Mt, PK, PS, and negatively with Es.

Description: Items admit personal and interpersonal shortcomings, a severe lack of self-confidence, a low threshold for self-blame and self-criticism, and a tendency to give up in the face of even minor adversity. It is the most sensitive of the content scales to ego-syntonic pathological dependency.

Interpretation: High scorers feel slower; less capable, intelligent, coordinated, attractive, likeable, self-confident, and resolute, and in many other ways less adequate than others. They feel so overwhelmingly flawed, incompetent, and

inferior to others that the independent management of daily life may seem out of the question, necessitating dependent and self-abasing attachments onto others.

Low Scores: Suggest relative freedom from negative self-attitudes, especially in the context of social interaction. Such scores affirm personal adequacy, self-confidence, competence, and independence. Within psychiatric populations, very low scores may reflect an inflated self-concept, as in mania, and possible grandiose ideation or delusions.

Most Useful Comparisons: High scores: Scales A, 7, 8, and 9, *Sc1, Sc2, Sc3, Sc4, Sc5, Sc6, Si3, OBS, DEP, DEP3, BIZ, WRK, TRT, NEGE*. *LSE* may be contrasted with *DEP* in terms of the locus of control construct, with *LSE* being more external than *DEP*. Whereas high *DEP* is worthless, more active, demanding, and relatively extrapunitive, high *LSE* is helpless and more passive, dependent, and intropunitive. *LSE* is highly intercorrelated with *OBS, DEP, WRK, and TRT*. An underlying theme in each of these scales is an inability to perform. *OBS* stresses the inability to make decisions and act on them; *DEP* stresses the inability to mobilize sufficient personal resources to engage life; *WRK* stresses the inability to produce output in the context of employment; and *TRT* stresses the inability to rise above helplessness and despair to grapple with personal problems. Together, these scales form a quintet for which the theme of motivational disability may be almost as significant as their common core of negative emotionality. That is, the respondent showing peaks on these scales is reporting feeling immobilized and helpless. Reference to *LSE* and *BIZ* can be especially useful in interpreting high Scale 8 scores, with these two content scales reflecting the contributions of negative self-attitudes and psychotic thinking, respectively. Low scores: Scales 9, *Pd1, Pd2, Pd3, Pa1, Pa3 (low), Ma1, Ma2, Ma3, Ma4, Ma-S, Ma-O, ANG1, ANG2, CYN1, CYN2, ASP1, ASP2, TPA1, TPA2, AGGR, PSYC, DISC*. Low *LSE* scores reflect inflated self-esteem that may have a basis in narcissism, psychopathy, paranoid ideation, or mood disorder (mania).

Low Self-Esteem (LSE)

The *LSE* scale contains 24 items, 21 True, 3 False. It comprises items admitting personal and interpersonal shortcomings. The high scorer feels slower, less capable, less intelligent, less coordinated, less attractive, less likable, less self-confident, less resolute, and in many more general ways less adequate than others. Indeed, the high *LSE* respondent feels so overwhelmingly flawed, incompetent, and inferior to others that the independent management of life may seem out of the question, making him or her vulnerable to charity case” dependent attachments onto others, in which dependency gratifications are paid for in the coin of self-abasement. It is the most sensitive of the content scales to ego-syntonic pathological dependency. The pattern of empirical correlates among the outpatients studied by Graham et al. (1999) appears to correspond closely to this description, but the men appeared more anxious and somatically focused, with histories of physical abuse, whereas the women were seen as more sad, dependent, isolated from others, and with histories of suicide attempts. Ben-Porath and Sherwood (1993) divided *LSE* into Self-Doubt (*LSE1*) and Submissiveness (*LSE2*).

Components: 2

Self-Doubt LSE1

11 items; 8 keyed *True*

Items are all negative self-attributions that are mostly phrased in such a way as to convey, not self-doubt, but the *conviction* that one is inferior and inadequate. That is, these items assert negative self-attitudes that are relatively fixed and that sum to an overall negative or devalued identity. Low scores reflect a positive if not exalted and aggrandized self-concept. Look for overconfidence and grandiosity.

The *LSE1* items are all negative self-attributions that are mostly phrased in such a way as to convey not self-doubt, but *conviction* that one is inferior and inadequate. That is, *LSE1* items assert negative self-attitudes that are relatively fixed and that sum to an overall negative or devalued identity. It correlates with *DEP3* at .83. The Graham et al. outpatients were described as sad/dysthymic/depressed, hopeless, feeling insecure, inferior and like a failure, self-degrading and self-doubting, interpersonally sensitive, and as coping poorly with stress, but the men were additionally described as anxious, worrying, obsessive-compulsive, histrionic, pessimistic, agitated, angry, resentful, overwhelmed, feeling that life is a strain, and having disturbed sleep and somatic complaints, while the women were seen as sensitive, passive-submissive and introversive, with narrow interests and low aspirations/achievement orientation. The correlates found for the Green et al. (2006) inpatients overlapped considerably with those they reported for *DEP* component scales, but with indecision and poorer concentration, more tension, self-consciousness, emotional withdrawal, blunted affect, loss of interest, motor retardation, feelings of inferiority, somatic concerns, and histories of sexual abuse.

Submissiveness LSE2

6 items; all keyed *True*

Items reflect passivity, a servile obedience to others and, by implication, an avoidance of responsibility. Low scores reflect independence, social confidence, and a sense of inner strength and competence. Cf. *Ma4*.

The *LSE2* items reflect passivity, a servile obedience to others and, by implication, an avoidance of responsibility. In the Graham et al. (1999) outpatients, interpersonal sensitivity was the only correlate applying to both genders.

Additionally, their men were described as anxious, nervous, passive, complaining of sleep disturbance, and having been physically abused, while their women were described as passive and submissive in relationships, overly compliant, neither self-reliant nor achievement oriented, having few or no friends, and with a history of suicide attempts. The Green et al. (2006) inpatients were described in terms similar to those these investigators recorded for

LSE1 but, in addition, they were described as suspicious and showing unusual thought content, hallucinatory behavior, and social/interpersonal as major problem areas. There is an interesting tension between the two components in that, when both are elevated, the high scorer seems to be saying, “I’ll gladly do whatever you tell me to, but I’m so clumsy and incompetent that you can’t expect me to do anything but bollix it up.” This would, among other things, suggest an affinity between *LSE* and interpersonal tactics, such as studied incompetence, that might be seen in some contexts as passive-aggressive and in others as self-defeating. However, *LSE* carries a primary implication of a collapse in normal-range defensive operations in which the ordinary maneuvers to shore up self-esteem, to put the best face on one’s actions and intentions, and to save face and seek acceptable excuses for one’s shortcomings are abandoned. *LSE1* contributes most directly to this aspect of *LSE*; *LSE2* extends the theme closer into the area of interpersonal interaction, where the renunciation of self-esteem culminates in an acceptance of the humiliation of servility.

Low scores on *LSE* suggest relative freedom from negative self-attitudes, especially in the context of interaction with others. Such scores affirm personal adequacy, self-confidence, competence, and independence. Within psychiatric populations, very low scores may reflect an inflated self-concept and possible grandiose ideation or delusions.

Relations to Other Scales

LSE may be contrasted with *DEP* in terms of the locus of control construct, with *LSE* being more “external” than *DEP*, whereas the high *DEP* scorer feels worthless and is more active, demanding, and relatively extra-punitive, the high *LSE* scorer feels helpless and is more passive, dependent, and intropunitive. *LSE* is highly intercorrelated with *OBS*, *DEP*, *WRK*, and *TRT*. An underlying theme in each of these scales is an inability to perform. *OBS* stresses the inability to make decisions and act on them, *DEP* stresses the inability to mobilize sufficient personal resources to engage life, *WRK* stresses the inability to produce output in the context of employment, and *TRT* stresses the inability to rise above helplessness and despair in order to grapple with personal problems. Together, these scales form a quintet for which the theme of motivational disability may be almost as significant as their common core of negative emotionality. That is, the respondent showing peaks on these scales is reporting feeling like a “basket case”: depleted, immobilized, blocked, and helpless. As noted earlier, reference to *LSE* and *BIZ* can be especially useful in the interpretation of high Scale 8 scores, with these two content scales reflecting the contributions of negative self-attitudes and psychotic thinking, respectively.

General Problem Areas Cluster

SOD—Social Discomfort

- assesses comfort levels in social situations

T-Scores > 65 are indicative of individuals who:

1. are shy and socially introverted
2. would rather be alone than with other people
3. dislike parties and other group activities
4. do not initiate conversations

T-Scores < 40 are indicative of individuals who:

1. are socially extroverted and sociable
2. enjoy parties
3. are easily able to initiate conversations

Content and Content Component Scales: *Social Discomfort (SOD)*

Items: 24; 13 keyed *True*

Major Internal Correlates: Scales *A*, *7* and *0*, *D1*, *D-O*, *Hy1*, *Pd3*, *Ma3*, *Si1*, *Si2*, *DEP*, *LSE*, *WRK*, *TRT*, *INTR*.

SOD/Social Discomfort Shy, withdrawn, uneasy with others, introverted, dislikes social events, prefers to be alone.

Persons with low scores are likely to be secure, relaxed, achievement oriented, assertive, and unlikely to be depressed or experience somatic symptoms.

Description: A bipolar scale, with high scores connoting introversion and low scores connoting extroversion. Three-quarters of the items overlap Scale *0*. Items express shyness and self-consciousness; fears of embarrassment, awkwardness, and ineptitude; conversational reticence; a desire for low social visibility; the avoidance of crowds, parties, and strangers; and a preference for being alone. The theme of interpersonal aversiveness is stronger in *SOD* than in Scale *0*.

Interpretation: High scorers seek to avoid other people, both individuals and groups, because they feel uneasy and awkward in such situations, and because they say they are happier being alone. The high scorer is not claiming loneliness, although this failure may represent a defensive denial of loneliness in some respondents.

Low Scores: Suggest a gregarious, outgoing style, with an enjoyment of interaction whether with individuals or in groups. They have a high level of social comfort and confidence, and are regarded as friendly, fun-loving, participative, and flexible. Sizeable $SOD2 > SOD1$ differences tend to identify individuals who have difficulty feeling at ease either alone or in the company of others. Very low scores on both components suggest a glib but superficial interactional style and are consistent with those manic/hypomanic syndromes that have high social hunger (and high social turnover) as a cardinal feature.

Most Useful Comparisons: Scales *A, L, F, K, 2, 6, 7, 8*, and *9, D5, Hy1, Hy2, Pd2, Pd3, Pa1, Sc1, Ma3, DEP, BIZ, CYN, ASP, ASP1, ASP2, AGGR, PSYC, DISC, NEGE, INTR, Re, GF*. With Scales *2* high and *9* low, high *SOD* reflects the kinds of anergic withdrawal and social anhedonia seen in depressive syndromes. With primary elevations on Scales *F, 6*, and *8*, high *SOD* may indicate schizophrenia-spectrum interpersonal aversiveness and social withdrawal, the avoidant wariness that is grounded in paranoid suspiciousness and concerns for one's personal safety, or both. *SOD* scores in a region of $55T$ to $65T$, when *SOD2* exceeds *SOD1*, are seen in borderline syndromes. Low *SOD* scores, especially when *SOD1* is low, can indicate warmth and a capacity for closeness with others when Scales *L, 2, 7*, and *8* are relatively low, *K* is in a $55T$ to $65T$ range, and raw *K* exceeds the non-*K*-corrected raw score on *Pt*. Low *SOD* scores in which *SOD1* exceeds *SOD2* are consistent with socially aggressive (see *Pd3*), if not narcissistic (check scores on *LSE*, Scale *9*) and psychopathic (check scores on *Pd2, ASP2, Re, GF; ASP > CYN*), features, as well as with manic/hypomanic states.

Components: 2

Introversion SOD1

16 items; 8 keyed *True*

Items emphasize anhedonia, the avoidance of group and social situations, an aversion to interpersonal interaction, and a preference for being alone. More behavioral than *SOD2*, *SOD1* contains all of the items of *Si2*. Ben-Porath and Sherwood (1993) have suggested that a low score on *SOD1* coupled with a high score on *SOD2* may reflect an aspiration to be more socially involved and a desire for an increased sense of personal comfort and control in interaction. This pattern is akin to stage fright, in which others are not rigidly avoided but simply approached with a sense of anxious trepidation. Cf. *INTR*. Very low scores may reflect a drive to become lost in the crowd and an intolerance of being alone.

Shyness SOD2

7 items; 4 keyed *True*

Items reflect self-consciousness, social inhibition, bashfulness, ease of embarrassment, and discomfort in social interaction. *SOD2* is completely contained in *Si1*. High scorers lack self-confidence and dread being the center of attention. They fear that they will be regarded as awkward or inept. Others view them as reticent and standoffish. Low scores reflect self-confidence and an uninhibited, outgoing style. In some cases, low scores may reflect social fearlessness, aggressive sociability, and psychopathic insouciance. Cf. *Pd3* and *Ma1*.

Social Discomfort (SOD)

The *SOD* scale contains 24 items, 13 True, 11 False. Sixteen of the items overlap with Wiggins' Social Maladjustment (*SOC*). Eighteen (75 percent) of the *SOD* items overlap with Scale 0 (*Si*), 10 on *Si1* and with all 8 of the items on *Si2*, and most of the nonoverlapping items express a preference for being alone; hence, the theme of interpersonal aversiveness is a good deal stronger in *SOD* than in *Si*. Like *Si*, *SOD* has a conspicuously bipolar character, with high scores connoting introversion and low scores connoting extraversion. Ben-Porath and Sherwood (1993) divided *SOD* into two components: Introversion (*SOD1*) and Shyness (*SOD2*). *SOD1* emphasizes the avoidance of group and social situations, an aversion for interpersonal interaction, and a preference for being alone. It correlates with *Si2* at .92. Very low *SOD1* scores may reflect a drive to become "lost in the crowd" and an intolerance of being alone. Containing all of the items of the *Si2* subscale (Social Avoidance), *SOD1* is the more "behavioral" of the two components. The correlates found for the Graham et al. (1999) outpatients included interpersonal sensitivity, introversion, depressed, feeling pessimistic and hopeless, and presenting with sleep disturbance and suicidal ideation, as well as, for men, insecure, suspicious, obsessive-compulsive, anxious, self-doubting, self-degrading, and self-punishing, feeling like failures, and likely to report somatic problems and physical health concerns, and for women, socially awkward, unconcerned with social status issues, neither achievement oriented, energetic, aspiring, nor extroverted, having few or no friends, diagnosed as dysthymic/depressed, and receiving anti-anxiety or antidepressant medication at the time of intake. The Green et al. (2006) inpatients showed anxiety, emotional withdrawal, guilt feelings, depressive mood, motor retardation, blunted affect, felt that doing nothing is a struggle, and had a history of sexual abuse and suicide attempts. *SOD2* is less than half the length of *SOD1* and emphasizes the more subjective and emotional features of the parent scale. It correlates with *Si1* at .94, and conveys a sense of discomfort, effort, difficulty, inhibition, and fear of embarrassment that pervades interactions with others, especially strangers, and in group situations. The correlates found for the Graham et al. outpatients included interpersonal sensitivity and, for men, passivity. Their women patients were additionally described as shy, introverted, having few interests, being non-energetic, non-competitive and neither achievement oriented nor aspiring, and failing to create a favorable first impression. The correlates found for the Green et al. inpatients essentially duplicate those these investigators found for *SOD1*. The high *SOD2* scorer is self-consciously lacking in

social skill and, although not necessarily avoidant in the way characteristic of the high *SOD1* scorer, he or she is likely to be seen as reticent and standoffish. The low *SOD2* scorer, by contrast, manifests an uninhibited sociability, enjoys high social visibility, and impresses others as socially intrepid, forward, and mixing easily. All of the *SOD2* items are contained in the *S/1* subscale (Shyness/Self-Consciousness). The high *SOD* scorer, then, seeks to stay away from others, whether individuals or groups, because he or she feels uneasy and awkward in such situations, and because being alone is felt to be happier. Thus, the high *SOD* scorer is not claiming loneliness, although this may represent a defensive denial of loneliness in some respondents. Low *SOD* scores, then, reflect a gregarious, outgoing style, the enjoyment of interaction, whether individually or in groups. Consistent with the opposite of social discomfort, the low *SOD* scorer evidences a high level of social comfort and confidence by being friendly, fun loving, talkative, participative, and flexible. Sizable *SOD2-SOD1* differences tend to identify individuals who have difficulty feeling at ease either alone or in the company of others. Ben-Porath and Sherwood have suggested that a low *SOD1* score coupled with a high *SOD2* score may reflect an aspiration to be more socially involved and a desire for an increased sense of personal comfort and control in interaction. This pattern is somewhat akin to stage fright, in which others are not rigidly avoided but simply approached with a sense of anxious trepidation. Very low scores on both components suggest a glib but superficial interactional style and are consistent with those manic/hypomanic syndromes having high social hunger (and high social turnover) as a cardinal feature.

The Graham et al. (1999) outpatients with high *SOD* scores showed interpersonal sensitivity, shyness, and social awkwardness, but they were also often seen as depressed and having suicidal ideation. The men were described in terms suggesting more severe and pervasive (e.g. suspicious, resentful, self-degrading) problems than those used to describe the women.

Relations to Other Scales

In the context of high scores on Scale 2 and low scores on Scale 9, high *SOD* scores reflect the kinds of anergic withdrawal and social anhedonia seen in depressive syndromes (see *INTR*, below). In profiles having primary elevations on *F* and Scales 6 and 8, high *SOD* scores may indicate schizophrenia spectrum interpersonal aversiveness and social withdrawal, the avoidant wariness that is grounded in paranoid suspiciousness and concerns for one's personal safety, or both. *SOD* scores in a region of *T*-55–65, when *SOD2* exceeds *SOD1*, are seen in borderline syndromes. Low *SOD* scores, especially when *SOD1* is low, can indicate warmth and a capacity for closeness with others when *L* and Scales 2, 7, and 8 are relatively low; *K* is in a *T*-55–65 range; and the raw *K* score exceeds the non-*K*-corrected raw score on *Pt*. Low *SOD* scores in which *SOD1* exceeds *SOD2* are consistent with narcissistic (check scores on *LSE* and Scale 9) and psychopathic (check scores on *Pd2*, *ASP2* [*ASP* exceeds *CYM*], *Re*, and *GF*) features, as well as with manic/hypomanic states.

FAM—Family Problems

- assesses intra-familial difficulties

T-Scores > 65 are indicative of individuals who:

1. describe considerable discord in current family or family of origin
2. describe their families as lacking in love, understanding, and support
3. resent the demands and ignore the advice from their families
4. feel angry/hostile toward their families
5. see marital relationships as involving unhappiness and a lack of affection
6. describe family members as nervous and having quick tempers

T-Scores < 40 are indicative of individuals who:

1. describe their families in generally positive terms
2. see families in general as loving, understanding and supportive
3. deny feelings of anger and resentment toward their families
4. do not see marital relationships as involving unhappiness and a lack of affection

FAM/Family Problems Family discord, unhappy childhood, difficult and unhappy marriages, families that do not express much love but are rather quarrelsome and unpleasant, possibly an abusive childhood.

Content and Content Component Scales: *Family Problems (FAM)*

Items: 25; 20 keyed *True*

Major Internal Correlates: Scales *A*, *4*, and *8*, *Pd1*, *Pd4*, *Sc1*, *Si3*, *MDS*.

Description: Items reflect family disharmony and dissension, in which conflict, neglect, jealousy, and misunderstandings contribute to a turbulent and unpleasant family atmosphere and to alienation among family members. By implication, the family emerges as an unsuitable venue for emotional nourishment because of a lack of attention, affection, and support, leading to feelings of deprivation, bitterness, and hostility toward family members.

Interpretation: High scorers not only feel deprived and mistreated by family members, but they also appear to have acquired or augmented a set of dispositions that maintains both intrafamilial and more generalized enmity and insecurity into adulthood. Others are apt to consider them immature and overreactive people who harbor grave doubts and deeply negative attitudes toward themselves, but who are equally mistrustful and disparaging of others. This pattern of correlates is reminiscent of Borderline Personality Disorder. The pattern is also common to alcohol and other substance abuse. Ben-Porath and Sherwood (1993) suggested that high scores on *FAM2* when *FAM1* is low indicate disengagement from family. This pattern would also seem to suggest a much greater sense of indifference, perhaps with some feeling of sorrow about the shortcomings of family as a source of emotional provisions. The opposite pattern suggests the persistence of attachment in the midst of enmity and discord. When both components are elevated, a state of resentful alienation is suggested in which physical ties (i.e., association) have been severed but unresolved emotional attachments persist.

Most Useful Comparisons: Scales 4 and 8, *Pd1*, *Pd4*, *Sc1*, *Si3*, *CYN*, *CYN1*, *CYN2*, *ASP1*, *ASP2*, *MDS*. *FAM* and *Pd1* have somewhat different interpretive implications for the primary nature and locus of family conflict, with *FAM* referring to current family and family of origin in about equal measure, whereas *Pd1* refers more to the parental home in content, giving it a clear though not strong bias toward the family of origin. *Pd1* shows a relatively greater emphasis on the parents as restricting freedom, independence, and efforts toward emancipation. *MDS* tends to emphasize current home conflict. *FAM* conveys a relatively greater sense of family turbulence, pathology, and estrangement. *MDS* > *FAM* > *Pd1* may better reflect current family difficulties, whereas the reverse pattern suggests that family strife may be largely confined to the parental home. The patient's age, family history, and current family circumstance may bear importantly on interpretations of *Pd1*, *MDS*, and *FAM* and its component scales. Peak elevations on *CYN* when *FAM* is also high imply a distrust and dissatisfaction with intimates that has apparently generalized to others. Distrust and dissatisfaction may reach paranoid proportions when *FAM* and *BIZ* are peaked. The pattern of high scores on *FAM* and *ASP* when *ASP* exceeds *CYN* and *SOD1* is low (and *SOD1* is higher than *SOD2*) appears to be the content scale equivalent of the psychopathic 4-9 profile type. Clinically, this pattern is associated with immaturity and substance abuse, and with assaultiveness and destructiveness. Cf. *Pd1* and *MDS*.

Family Problems (FAM)

The *FAM* scale contains 25 items, 20 True, 5 False. *FAM* contains 10 items that appeared on the Wiggins Family Problems scale and 6 that overlap *PdI* (Familial Discord). *FAM* items are about evenly balanced between current family and family of origin. The relatively high correlations between *FAM* and Scales 4 and 8 cannot be accounted for entirely by overlapping items, indicating that *FAM* may have a wider array of personological correlates than might be expected on the basis of its item content alone. This impression is confirmed in the findings of Butcher et al. (1990) in their ratings data from the re-standardization couples, and in the correlates Graham et al. (1999) found among their psychiatric outpatients. The re-standardization spouses rated their high *FAM* partners in terms suggesting emotional instability and loss of control; irritability, suspiciousness, hostility, and resentment; tension, worry, and fearfulness; dysphoric mood; dependency; and interpersonal ambivalence. The Graham et al. (1999) outpatients were seen as issuing from families in which emotional deprivation, discord, and abuse (men: physical; women: sexual) were common, but they were also described as depressed, hostile, resentful, and interpersonally sensitive.

The range and severity of these correlates is consistent with the view that positive emotional ties to family are essential to the kind of personal well-being that comes from feeling rooted in social life. A lack of sufficiently fostering primary relationships in childhood, and a stormy and contentious home atmosphere in particular, may bring about a level of personal deprivation and a pattern of negative social expectancies that leaves the individual ill-prepared for later developing the kinds of constructive relationships that lead to a sense of belongingness.

A substantially narrower set of correlates was found by Ben-Porath and Stafford (1993) in a forensic diagnostic sample of 113 men. Participants scoring high on *FAM* tended to show a history of poor relationships with fathers, siblings, family, spouses, and friends; had more frequently lost physical and legal custody of their children; and had been arrested while previously on probation.

High *FAM* scorers not only feel deprived and mistreated by family but also appear to have acquired or augmented a set of dispositions that maintain both intra-familial and more generalized enmity and insecurity into adulthood. They are apt to be seen by others as immature and over-reactive people who harbor grave doubts and deeply negative attitudes toward themselves but who are equally mistrustful and disparaging of others. This pattern of correlates is reminiscent of the pattern of traits in BPD. It is also a pattern that is common to alcohol and other substance abuse.

Ben-Porath and Sherwood (1993) found two *FAM* components: Family Discord (*FAMI*) and Familial Alienation (*FAM2*). The content of *FAMI* stresses intra-familial conflict and animosity, with members being seen as quarrelsome and disagreeable, oppressive and disapproving, annoying and ill-tempered. It correlates with *PdI* at .74, and with *ScI* at .72. The theme is one of the family as an unpleasant, noxious environment from which one would like to escape. The high *FAMI* Graham et al. (1999) outpatients were found likely to present with hostility, paranoid

ideation, and interpersonal sensitivity. Additionally, their men were said to issue from families lacking in love, to have family problems and complain of family discord, to resent and blame family members for their problems, to be sad, depressed, hopeless, rejected, insecure, intolerant of frustration, to get along poorly with coworkers, and to have histories of sexual abuse, while the women were seen as critical, argumentative, grouchy, and had made suicide attempts. The Green et al. (2006) inpatients were described as hostile, suspicious, and excited, and showed histories of sexual abuse and suicide attempts.

Less than half the length of *FAMI*, *FAM2* stresses an emotional detachment from family. The items are phrased descriptively and have low emotional valences. They simply report factual states of affairs, which, in some respondents, would be associated with longing, loss, and anger, but in others with a sense of at least partial equanimity or indifference. In either case, high *FAM2* scores imply that respondents severed ties in order to cut their losses with their family because of its inability or disinclination to provide a center of belonging and emotional support. However, the empirical correlates that Graham et al. (1999) found among their outpatients suggest that for high *FAM2* scorers, the severing of emotional attachments to family is not followed by the formation of alternative attachments. Thus, in addition to having family problems and coming from families lacking in love, these patients were described as lonely, having few or no friends, and self-destructive, either through suicide attempts (women) or through chronic alcohol and marijuana abuse (men). These investigators also found histories of physical (men) and sexual (women) abuse among high *FAM2* scorers. Additionally, their men were described as experiencing family discord, being self-degrading, and abusing alcohol and marijuana, while their women were seen as narcissistic, immature, histrionic and demanding of attention, and having an exaggerated need for affection, but also as critical, argumentative, overly sensitive to criticism, having difficulty trusting others, suspicious, angry, resentful, and feeling they get a raw deal from life. The Green et al. outpatients were seen as hostile and had histories of sexual abuse and suicide attempts. Ben-Porath and Sherwood suggested that high scores on *FAM2* when *FAMI* is (relatively) low indicate disengagement from family. This pattern would also seem to suggest a much greater sense of indifference, perhaps with some feeling of sorrow about the shortcomings of the family as a source of emotional provisions. The opposite pattern suggests the persistence of attachment in the midst of enmity and discord. When both components are elevated, a state of resentful alienation is suggested in which physical ties (i.e. association) have been severed but unresolved emotional attachments continue.

Components: 2

Family Discord FAM1

12 items; 11 keyed *True*

Items stress intrafamilial conflict and animosity, with members being viewed as quarrelsome and disagreeable, oppressive and disapproving, annoying and ill-tempered. The theme is one of the family as an unpleasant, noxious environment from which one would like to escape. Cf. *Sc1*.

Familial Alienation FAM2

5 items; two keyed *True*

Items reflect an emotional detachment from family. The items are phrased descriptively and have low emotional valences. They report factual states of affairs that, in some, would be associated with longing, loss, and anger, but in others with a sense of at least partial equanimity or indifference. In either case, high scores imply that the respondent severed ties in order to cut his or her losses with family for their inability or disinclination to provide a center of belonging and emotional support. The empirical correlates found by Graham et al. (1999) among their outpatients suggest that for high *FAM2* scorers, the severing of emotional attachments to family is not followed by the formation of alternative attachments. Thus, these patients were described as lonely, having few or no friends, and self-destructive, either through suicide attempts (women) or through chronic alcohol and marijuana abuse (men). These investigators also found histories of physical (men) and sexual (women) abuse among high *FAM2* scorers.

Relations to Other Scales

Despite the overlap between *FAM* and *PdI* ($r = \sim .80$), the two scales have somewhat different interpretive implications for the primary nature and locus of family conflict. As noted previously *FAM* refers to current family and family of origin in about equal measure, whereas reference to the parental home more clearly dominates the content of *PdI*, giving it a clear, albeit not strong, bias toward the family of origin. *PdI* shows a relatively greater emphasis on the parents as restricting freedom, independence, and efforts toward emancipation. *FAM* conveys a relatively greater sense of family turbulence, pathology, and estrangement. As a result, scores on *FAM* exceeding those on *PdI* may be a better reflection on current family relations, whereas the reverse pattern suggests that family strife may be largely confined to the parental home. The patient's age, family history, and current family circumstance, of course, may bear importantly on interpretations of *PdI*, *FAM*, and the *FAM* component scales. Peak elevations on *CYN* when *FAM* is elevated imply distrust and dissatisfaction, if not enmity, with intimates that have apparently generalized to others. Distrust and dissatisfaction reach paranoid proportions when *FAM* and *BIZ* are peaked. The pattern of high scores on *FAM* and *ASP* when *ASP* exceeds *CYN* and *SOD* is low (and *SOD1* exceeds

SOD2) appears to be the content scale equivalent of the psychopathic 49/94 profile type. Clinically, this pattern is associated with immaturity and substance abuse and with assaultiveness and destructiveness.

WRK–Work Interference

- scale assesses attitudes and behaviors likely to contribute to poor work performance

T-Scores > 65 are indicative of individuals who:

1. report a wide variety of attitudes/behaviors that are likely to contribute to poor work performance
2. may be questioning their career choices
3. say their families have not approved of their career choices
4. express negative attitudes about co-workers
5. have a poor self-concept
6. are obsessive and have troubles concentrating
7. have difficulties making decisions and show poor judgment
8. feel tense and fearful
9. report that they are not able to work as they once were
10. report feeling tired of work, lack energy and are sick of what they have to do
11. give up easily and shrink from facing a crisis

T-Scores < 40 are indicative of individuals who:

1. do not report attitudes/behaviors that inhibit work performance
2. seem to be ambitious/energetic
3. express positive attitudes towards co-workers
4. seem comfortable with career choices
5. can concentrate and make decisions without undue difficulty
6. can work effectively

WRK/Work Interference Personal difficulties that interfere with work; tension, worry, obsessiveness, difficulty concentrating, career indecision and/or dissatisfaction, poor concentration, dislike of coworkers; difficulty initiating work-related activities; little family support for career choice; easily defeated by difficulties.

Content and Content Component Scales: *Work Interference (WRK)*

Items: 33; 28 keyed *True*

Major Internal Correlates: Scales *A*, *7*, *8*, and *0*, *D1*, *D4*, *D5*, *D-O*, *Hy3*, *Pd5*, *Pd-O*, *Sc3*, *Sc4*, *Si3*, *ANX*, *OBS*, *DEP1*, *DEP3*, *LSE1*, *TRT1*, *NEGE*, *Mt*, *PK*, *PS*, and negatively with *Es*.

Description: Items reflect a broad range of problems and impediments to performance in employment, including tension, worry, fearfulness, and feeling overwhelmed; defeatist and pessimistic attitudes; fatigue, inertia, and lack of initiative; distractibility and indecision; lack of self-confidence and self-esteem; irritability, rebelliousness, and oppositionality; and a tendency to give up in the face of obstacles. Almost 40% of the items contain the word *work* or one of its cognates.

Saturated with the First Factor, *WRK* is a general measure of distress and disability that has been shaped to the context of work, emphasizing the kinds of problems that have adverse effects on productivity. The interferences covered in *WRK* include both interpersonal difficulties and the attitudes and symptoms that impair efficiency and impede output.

Interpretation: High scorers either feel impaired and incapacitated or wish to be viewed that way.

Low Scores: Suggest self-confidence; perseverance; an adequate fund of energy; the capacity to marshal one's abilities in the service of productivity on the job, ability to cooperate with coworkers (i.e., teamwork), and an ability to limit the influence of personal problems and symptoms on job performance.

Most Useful Comparisons: Scales *A*, *4*, *7*, *8*, and *9*, *D4*, *Pd2*, *Pd4*, *Pa1*, *Sc3*, *Sc4*, *Ma1*, *ANX*, *OBS*, *DEP*, *ASP1*, *ASP2*, *TRT*, *DISC*, *NEGE*, *Re*, *MAC-R*, *APS*, *AAS*.

Because of its saturation with the First Factor, the interpretive implications of *WRK* are most likely to be realized when it exceeds Scale *A* in elevation. Although problems that may interfere with employment performance are suggested by elevations on *WRK* alone, such elevations cannot be taken to indicate occupational malfunctioning specifically. The requirement that *WRK* exceed *A* strengthens the implication of specific work interferences to the extent of this difference. Recalling the high intercorrelations among *OBS*, *DEP*, *LSE*, *WRK*, and *TRT*, scores on *WRK* should always be compared with those on the other scales in this group to gain additional insight into the kinds of problems at work. High scores on Scales *4* and *9*, *Pd2*, *Ma1*, *ASP1*, *ASP2*, *DISC*, *Re*, and *MAC-R* raise the question of exaggeration of disability and compensation seeking. High scores on *MAC-R*, *APS*, and *AAS* may suggest disability on the basis of substance abuse.

Components: None

Work Interference (WRK)

The *WRK* scale contains 33 items, 28 True, 5 False. Twelve overlap with the 37-item Tydaska and Mengel (1953) Work Attitude (*Wa*) scale. As noted in the discussion of *TPA*, almost 40 percent of the items contain the word *work* or one of its cognates.

Of all the content scales, *WRK* is the one most saturated with first factor variance, achieving correlations with Welsh's *A* at $\sim .90$ (8 items overlap with *A*). It is, in effect, a general measure of distress and disability that has been trimmed to the context of work, emphasizing the kinds of problems that have adverse effects on productivity. As such, it reflects an admixture of content that includes defeatist and pessimistic attitudes; anergia and impersistence; indecision and distractibility; irritability and rebelliousness; bitterness and oppositionality; a lack of initiative and ambition; a lack of enthusiasm and competitiveness; a lack of self-confidence and self-esteem; and a proneness to tension, worry, and fearfulness. Thus, the interferences covered in *WRK* include both interpersonal difficulties and the kinds of attitudes and symptoms that impair efficiency and impede output. Low scores, then, imply self-confidence, perseverance, an adequate fund of energy and the capacity to marshal one's abilities in the service of productivity on the job, a capacity for cooperative interactions with fellow employees (i.e. teamwork), and an ability to limit the influence of personal problems and symptoms on job performance. Graham et al. (1999) found that their high *WRK* scoring outpatients were described in terms indicative of depression, and as tending to lack ambition. The women presented as more passive and dependent; the men as more angry.

Many individuals experiencing psychological problems find that their work deteriorates or that they are unable to maintain productive attitudes toward life. The *WRK* scale was developed to assess the possibility that the individual possesses attitudes or habits that would be counterproductive to rehabilitation efforts. The items on the scale center on the person's attitude toward work or his or her perceived inability to function in productive activities. The content themes include such beliefs or attitudes as inability to function or to make decisions, quick resignation when faced with difficulty, feelings of low success expectation, feeling weak and helpless, and possessing a dislike for work.

People who score high on this scale are presenting the view that they have many problems that prevent them from being successful at work. Therapists should be aware that work-related problems are or could become central problems in any person's life situation. Therefore, people with high scores on this scale may have a poor prognosis for achieving treatment success since their environmental pressures are likely to absorb much of their energies.

Relations to Other Scales

Because of its extensive shared variance with the first factor, the interpretive implications of *WRK* are most likely to be realized when it exceeds *A* in elevation. Although problems that may interfere with functioning in employment are suggested by elevations on *WRK* alone, such elevations cannot be taken to indicate occupational malfunctioning *specifically*. The requirement that *WRK* exceed *A* strengthens the implication of specific work interferences to the extent of this difference. Recalling the high intercorrelations among *OBS*, *DEP*, *LSE*, *WRK*, and *TRT*, scores on *WRK* should always be compared with those on the other scales in this group as a means of gaining additional insight into the kinds of problems that may most threaten work performance. See also *WRK* in the discussion of *TRT*, above.

TRT–Negative Treatment Indicators

- assesses attitudes toward psychotherapy

T-Scores > 65 are indicative of individuals who:

1. have negative attitudes about physicians and mental health professionals
2. feel that no one can understand them
3. believe that they have problems that they cannot share with anyone else
4. give up easily when problems are encountered
5. feel unable to make changes in their lives
6. are poor problem solvers
7. often show poor judgment
8. prefer pharmacotherapy to psychotherapy
9. have a difficult time making decisions

T-Scores < 40 are indicative of individuals who:

1. have generally positive attitudes about physicians and mental health workers
2. believe others can understand them and share problems with others
3. do not give up easily when they encounter problems
4. feel capable of making significant changes
5. show good judgment and are good problem solvers

TRT/Negative Treatment Indicators Dislike or distrust of helping professionals, discomfort in discussing difficulties, low level of self-disclosure, resistance to change, disbelief in the possibility of change, belief that no one can really understand or help them, preference for giving up rather than facing a crisis (M. Clark, 1996).

Content and Content Component Scales: *Negative Treatment*

Indicators (TRT)

Items: 26; 23 keyed *True*

Major Internal Correlates: Scales *A*, *7*, and *8*, *D5*, *Sc1*, *Sc4*, *Si3*, *OBS*, *DEP1*, *DEP3*, *LSE1*, *WRK*, *NEGE*, *Mt*, *PK*, *PS*, and negatively with *Es*.

Description/Interpretation: *TRT* is saturated with depressive variance; the correlation between *TRT* and *DEP* among psychiatric patients can be as high as .89. The empirical correlates of these two scales are likewise nearly identical (Butcher et al., 1990; Graham et al., 1999). Its items, 6 of which overlap *DEP* (4 of these on *DEP1*), reflect a range of dysphoric feelings and attitudes, including hopelessness about making plans and decisions, effecting changes, or reaching goals; feeling unhappy, apathetic, guilty, and irritable; feeling that others do not care or understand; and pessimism about and aversion to confiding in others, including doctors. Given the extensive shared variance between these two scales, it is doubtful that *TRT* scores can predict treatment outcome reliably among any common diagnostic group, and such scores may lead to unusually and unrealistically negative prognostications among patients diagnosed with depression for reasons discussed in Friedman et al. (2001) and Greene (2011). In some cases, higher *TRT* scores may predict *better* treatment outcomes (Rosik & Borisov, 2010). *TRT* may serve as a measure of depressive severity and immobilization, however.

The interpretation of low scores on *TRT* and its components is equally problematic. Although some low scorers on *TRT* may be adequately motivated, self-confident, planful, and persistent, they are likely to be less distressed and therefore less motivated for psychotherapy on that basis. Others obtaining low scores may appear grandiose and overconfident, and may take an insouciant and unreflective approach to self-disclosure and thus be impervious to psychotherapeutic efforts even when tolerant of them. The mere capacity to disclose personal information affords no guarantee that the material revealed can be discussed productively or insightfully (e.g., manic- and psychopathic-spectrum patients). Such patients, despite a tendency to obtain low and even very low scores on *TRT*, may pose challenges to the psychotherapist that are every bit as forbidding as those posed by high *TRT* scorers. For these reasons, both the positive and the negative predictive power of *TRT* are highly suspect. Until evidence of the validity of *TRT* for its intended purpose is forthcoming, this scale should be interpreted with caution.

Most Useful Comparisons: Scales *7* and *8*, *Pd5*, *Sc1*, *Sc2*, *Sc4*, *Si3*, *DEP1*, *DEP3*, *LSE1*, *NEGE*. See *DEP*.

The TRT scale was developed as a means of assessing the individual's potential to cooperate with treatment and to detect the presence of personality factors or attitudes in the client reflecting an unwillingness or inability to change. The scale includes attitudes or beliefs that reflect a rigid and noncompliant orientation toward personal change, such as a lack of insight into one's own motives, an unwillingness to discuss problems with others, a dislike of healthcare providers, an inability to work out problems, and alienation from others.

High scorers on this scale are presenting the view that they are unwilling or unable to change their life situation at this time and that they are pessimistic about the future. A therapist armed with this information in the early stages of treatment might attempt to deal with the individual's negative treatment views before they result in early termination of therapy. Note the high TRT score obtained by the individual reported in Figure 5.5.

The *TRT* scale contains 26 items, 22 True, 4 False. It is highly correlated with *DEP* (.77), with which it shares 6 items (23 percent), and the empirical correlates found by Graham et al. (1999) to describe high *TRT* scorers are highly similar (often identical) to those they found to describe high *DEP* scorers. As a whole, *TRT* seems to reflect a depressive state in which apathy, despair, and helplessness reach such a level of severity as to result in immobilization. Ben-Porath and Sherwood (1993) divided *TRT* into two components: Low Motivation (*TRT1*) and Inability to Disclose (*TRT2*).

Components: 2

Low Motivation TRT1

11 items; 10 keyed *True*

Items reflect apathy, an external locus of control, and a tendency to give up quickly in the face of obstacles because of a depletion of personal resources. The high scorer feels helpless and motivationally destitute to the point that struggle against adversity, or even planning to do so, is felt to be futile. Low scores reflect energy, optimism, self-confidence, and perseverance.

The *TRT1* items connote apathy, an external locus of control, and a tendency to quickly give up in the face of obstacles because of a depletion of personal resources. It correlates with *DEPI* at .86, and with *DEP* at .85.

The high *TRT1* scorer feels helpless and motivationally destitute to the point that struggle against problems and adversity, or even the formulation of plans to do so, is felt to be futile and pointless, leaving no alternative but to give up. The Graham et al. (1999) outpatients were seen as sad and depressed, pessimistic and hopeless with suicidal

ideation, anxious, insecure, coping poorly with stress, and giving up easily. In addition, their men were seen as self-degrading, obsessive-compulsive, feeling overwhelmed and that life is a strain, presenting somatic complaints, and having had prior outpatient treatment, while their women were seen as non-self-reliant, showed few interests, were not aspiring nor achievement oriented, had few or no friends, and had histories of suicide attempts. The Green et al. (2006) inpatients had a history of prior outpatient treatment and showed sexual inadequacy as a major problem, but their remaining correlates were almost identical to those these investigators found for *LSEI*.

Inability to Disclose TRT2

5 items; all keyed *True*

Items reflect a disinclination to volunteer personal information and significant discomfort when asked to do so.

TRT2 extends the theme of the futility of efforts at amelioration to the realm of discussion. High scorers do not wish to reveal information about personal problems, perhaps because of depressive immobility, hopelessness (in which case *TRT1* is also high), or both, or because previous attempts to confide in others have not produced relief. Low scorers report eagerness to discuss their problems.

TRT2 is less than half the length of *TRT1* and extends the theme of the futility of efforts at amelioration to the realm of discussion. It correlates with both *Si3* and *NEGE* at .64. All of the *TRT2* items reflect a disinclination to volunteer personal information and significant discomfort when one is asked to do so by others.

The high *TRT2* scorer does not wish to reveal information about personal problems. Significantly, for women at least, the reasons for such disinclination and discomfort are suggested in the empirical correlates found by Graham et al. (1999) to characterize their high *TRT2* scoring female outpatients, including histories of both physical and sexual abuse, few or no friends, and prior suicide attempts and psychiatric hospitalization. Thus, for women, if not for men, high *TRT2* scorer may reason that confiding in others has not worked out well in the past and may only increase one's personal discomfort without offering any countervailing benefits. Additional correlates found by Graham et al. included, for men: depression, complaints of fatigue and sleep disturbance, and developing physical problems in response to stress; for women: shyness and introversion, not having high aspirations, and a history of alcohol abuse and misdemeanor convictions; for both: suicidal ideation, and feeling that life is a strain. The Green et al. inpatients had drug abuse as a major problem, histories of alcohol abuse, and showed anxiety, guilt feelings, motor retardation, and hallucinatory behavior.

Because both the item content and the empirical correlates of *TRT* are so heavily biased toward depression (*all* of the empirical correlates from the re-standardization couples' *TRT* ratings for women are contained within the *DEP* correlates for women; Butcher et al., 1990), it is most improbable that scores on *TRT* or its components have much to contribute to estimates of prognosis for psychotherapeutic treatments. Indeed, it is doubtful that these scores can reliably contribute to questions of psychotherapeutic outcome even in depressive states. First, muteness can be a symptom of severe depression and, in this context, may be no more predictive of psychotherapeutic outcome than other vegetative symptoms of comparable severity. Second, the prognosis for psychotherapy in depression may be quite unstable, appearing guarded to poor in the depths of depressive episodes, only to improve markedly as symptoms such as insomnia, anorexia, and psychomotor retardation subside. Thus, *TRT* scores may better serve prediction and description in the area of depressive *severity* than as a specific and reliable indicator of negative prognostic factors for the psychotherapy of depression or any other conditions commonly treated psychotherapeutically. The interpretation of low scores on *TRT* and its components is equally problematic. Because low *TRT* scorers are adequately motivated, self-confident, plan-ful, and persistent, they are likely to be less distressed and therefore less motivated for psychotherapy. Others obtaining low scores may appear grandiose, inflated, overconfident, insouciant, and unreflective in their approach to self-disclosure, and hence be potentially impervious to psychotherapeutic efforts even when tolerant of them. The mere capacity to disclose personal information affords no guarantee that the material revealed can be discussed productively, reflectively, or insightfully. Manic and psychopathic spectrum patients come easily to mind in this regard. Such patients, despite a tendency to obtain low and even very low *TRT* scores, may pose challenges to the psychotherapist that are every bit as forbidding as those posed by high *TRT* scorers. For these reasons, both the positive and the negative predictive power of *TRT* are highly suspect. In a study of male inpatients undergoing treatment for chronic pain, for example, Clark (1996) found that although high *TRT* and *TRT1* scores predicted less improvement in physical capacities over the course of treatment, they predicted greater reductions in Beck Depression Inventory (BDI) scores, the latter effect being attributed to regression to the mean. *TRT* and *TRT1* scores also predicted higher levels of posttreatment dysfunction in these patients, indicating that high scorers were more impaired to begin with. *TRT2* was not significantly associated with changes related to treatment or with post-treatment functioning. Moreover, none of the *TRT* scales were related to premature termination of treatment. To be sure, the patients and treatment examined in this study are not typical of those psychotherapy and psychiatric settings in which *TRT* may be routinely applied. Overall, the research literature on *TRT* may be summarized as follows: The results from studies by Garcia, Kelley, Rentz, and Lee (2011), Gilmore, Lash, Foster, and Blosser (2001), and by Kotjahasan (2005) can be considered positive, but are at a minimum counterbalanced by the negative findings of Chisholm, Crowther,

and Ben-Porath (1997), Collins (1999), Craig and Olson (2004), Maiello, Salviati, De’Fornari, Del Casale, Rreli, Rusconi, and Piccione (2007), Minnix, Reitzel, Repper, Burns, Williams, Lima, Cukrowicz, Kirsch, and Joiner (2005), and by Rosik and Borisov (2010), and the mixed or equivocal findings of Coffield (2007) and Muench (1996). Indeed, in some cases, notably those of Chisholm et al. (1997), Maiello et al. (2007), and Rosik and Borisov (2010), the results suggest that, if anything, elevated scores on *TRT* are predictive of *positive* treatment outcomes or, precisely the opposite of what this scale was intended to predict. Thus until substantially more evidence of the validity of *TRT* for its intended purpose is forthcoming from traditional treatment venues, this scale should be interpreted conservatively and with due caution.

Relations to Other Scales

Recall that *TRT* is one of a cluster of scales that also includes *OBS*, *DEP*, *LSE*, and *WRK*. Of these, as noted earlier, *TRT* is most closely associated with *DEP*. Because the status of *TRT* as a predictor of problems that favor a poorer prognosis for psychotherapeutic endeavors is unknown at this time, it is premature to speculate on patterns between *TRT*, *DEP*, and other scales in this cluster.

DON’T FORGET

The content, *PSY-5*, and RC scales are often highly redundant with each other, such that score differences among those scales within the same domain (e.g., *BIZ*, *PSYC*, *RC6*, *RC8*, *CogProb*, and *DisOrg*) are likely to carry greater interpretive value than their similarities.

Supplementary Scales

- assist in the interpretation of the basic scales
- augment the coverage of clinical problems and disorders

Introduction

Since the earliest days following its publication, investigators have selected the MMPI item pool as a source for the development of new scales for the measurement of a bewildering array of variables. Hathaway and McKinley’s completion of the series of clinical scales based on pathological criterion groups produced no significant pause in scale development efforts. By the mid-1950s, these efforts had yielded a large number of scales, a plurality of which

had been developed by graduates and doctoral advisees from the University of Minnesota, or by their students in turn.

Following the example of the clinical scales, some of these efforts have been focused on psychopathological syndromes, or features of them, that were formerly unavailable in sufficient numbers to permit scale development. Examples of these include low back pain, neurodermatitis, ulcer personality, alcoholism, and pedophilia. One series of scales was developed to discriminate several conditions—somatization reaction, depressive reaction, anxiety reaction, conversion reaction, and paranoid schizophrenia—not from a background sample of normals but from a reference group of general psychiatric patients (Rosen, 1962). Still other efforts sought scales to detect psychopathological syndromes but preferred a rational/statistical strategy over the empirical group contrast methodology that shaped the basic clinical scales of the MMPI. The DSM-III (American Psychiatric Association, 1980) personality disorder scales of Morey et al. (1985) are examples. However, the vast majority of new MMPI scales have been built to aid the measurement or prediction of an unusually broad range of abnormal and normal traits involving achievements, attitudes toward self and others, behavioral dispositions, styles of inventory response, and others. Dahlstrom et al. (1975) listed 455 scales, a list that was known to be incomplete at the time it was published and, among others, did not include any of the 89 basic clinical and validity scales and their derivatives that they listed in 1972. Thus, even in 1975, the total number of MMPI scales almost certainly exceeded the number of items on the test.

By far the greatest number of scales developed since the inception of the MMPI have not made their way to more than a handful of users. Many were probably never used by other than their authors.

The reasons for the limited penetration of such scales are not hard to find, among them

- a) scales developed for overly specific purposes;
- b) the use of samples of inadequate size or representativeness;
- c) inadequate or inappropriate contrast groups;
- d) inadequate test–retest or internal consistency reliability;
- e) inadequate concurrent or predictive validity;
- f) failures on cross-validation or excessive cross-validation shrinkage;
- g) excessive redundancy with preexisting and/or better validated scales;
- h) excessive redundancy with the major sources of variation within the item pool (poor discriminant validity);
- i) problems with construct definition or understanding;

- j) a host of other problems including awkward, obscure, or misleading scale names, uncertainties about the availability or appropriateness of norms, difficulties in retrieval (e.g. unpublished dissertations or reports in journals of limited circulation), and simple lack (or loss) of interest.

Considering the time, personnel, and support required to mount and publish investigations justifying a scale's clinical or research application, it is not surprising that so few scales have been successful.

The formation of a standard "set" of supplementary scales occurred slowly. The initial stimulus was provided by the mention of some of the newer scales in the course of MMPI presentations at seminars, colloquia, and workshops by early publicists, especially Paul Meehl and Harrison Gough. A further important impetus was the inclusion of most of them in the Welsh and Dahlstrom (1956) compendium, *Basic Readings on the MMPI in Psychology and Medicine*, and, a year later, the provision of norms for scoring them (Hathaway and Briggs, 1957). To this point, users of the MMPI could select for scoring those scales that appeared to be applicable to their particular practices and populations, ignoring the rest. It was not until the 1960s and the advent of machine scoring that scores for these scales became routinely available as a set. The first automated MMPI scoring system becoming operational at the Mayo Clinic in 1961, but The Psychological Corporation, the Consulting Psychologists Press, and many other commercial concerns made computer scoring services available shortly thereafter. These services ultimately formed what became known alternatively as the supplementary or research scales into a distinct set.

The first of the supplemental scales was actually Social Introversion (Si; Drake, 1946), which became formally incorporated as the last of the standard clinical scales only in 1951. The most frequently reported supplemental scales were 11 in number and usually presented in the following order: Welsh's (1956) factor scales A and R; Barron's (1953) Ego Strength scale (Es); Hanvik's (1949) Low Back Pain scale (Lb); H. L. Williams' (1952) Caudality scale (Ca); Navran's (1954) Dependency scale (Dy); Gough, McClosky, and Meehl's (1951) Social Dominance scale (Do); Gough, McClosky, and Meehl's (1952) Social Responsibility scale (Re); Gough's (1951) Prejudice scale (Pr); Gough's (1948a, 1948b) Social Status scale (St); and Cuadra's (1956) Control scale (Cn). Although this series persisted for many years, scale development continued apace and many services expanded to accommodate and report scores on additional supplementary scales, notably, J. A. Taylor's (1953) Manifest Anxiety scale (At or MAS); Kleinmuntz' (1961a) College Maladjustment scale (Mt); MacAndrew's (1965) Alcoholism scale (Alc or MAC); and Megargee, Cook, and Mendelsohn's (1967) Overcontrolled-Hostility scale (O-H).

There is no doubt that this list of scales, or any similar list of non-routinely interpreted scales, is somewhat arbitrary. Few if any of them had proved themselves in routine clinical applications at the time they became aggregated into a semi-standard panel of scores. Their attainment of this position of status rested on a combination of their reasonably

scrupulous construction, and a degree of consensus among the MMPI opinion leaders at the time that these scales held promise for clinical decision making, application to research, or both.

The re-standardization that led to the release of the MMPI-2 in 1989 created an opportunity to review an immense array of scales, those that had been available in 1975 (as compiled by Dahlstrom et al.), and those that had accumulated in the interim. Among the almost-limitless bases for the selection of a set of supplemental scales to succeed those that had become more or less standard for the MMPI environment was the effect of the 90 items that were not retained in the transition from the MMPI to the MMPI-2. The content of these discontinued items varied widely but disproportionately represented interests and hobbies (17 items); religion (16 items); interpersonal relationships (14 items); negative affects (12 items); and bodily functions, mostly urinary/excretory (9 items; Greene, 1991a).

Thus, scales importantly or entirely (e.g. Wiggins, 1966, Religious Fundamentalism scale [REL]) consisting of such items became ineligible for retention on the MMPI-2. A potentially important factor guiding the selection of a new set of supplemental scales was the availability of research attesting to the validity of several scales that had accumulated during the preceding 40 years. Indeed, the majority of the scales chosen for the supplemental MMPI-2 scales (A, R, Es, O-H, Do, Re, Mt, and MAC-R) appear to have been selected on this basis.

The current sequence of supplemental scales for the MMPI-2 is as follows: A; R; Es; Do; Re; Mt; Keane, Malloy, and Fairbank's (1984) Post-Traumatic Stress Disorder (PK); Schlenger and Kulka's (1987) Post-Traumatic Stress Disorder (PS); Hjemboe, Butcher, and Almagor's (1992) Marital Distress (MDS); Cook and Medley's (1954) Hostility (Ho); O-H; MAC-R; Weed, Butcher, McKenna, and Ben-Porath's (1992) Addiction Admission (AAS) and Addiction Potential (APS); and Peterson and Dahlstrom's (1992) Gender Role—Masculine (GM) and Gender Role—Feminine (GF). PK and PS, MDS, and GM and GF were, like the supplementary scales for the MMPI, selected mostly because of their judged promise for augmenting the interpretive possibilities of the test and not on the basis of accumulated research supporting their validity. (See the MMPI-2 Manual, Butcher et al., 2001, Table B-6 for a listing of the item composition and scoring directions for the MMPI-2 supplementary scales; and Tables A-12–A-13 for the uniform T-score conversions from raw scores for these scales.)

Factor Scales A and R

Welsh's purpose in developing the A and R scales was to provide a convenient means of locating respondents along the two primary dimensions that had been repeatedly identified in factor analyses of the basic clinical and validity scales of the MMPI. Although prior analyses had found varying numbers of factors, depending on the sample and the numbers of scales included in each, the primary dimension had consistently shown high positive loadings on

Scales 7 and 8 and high negative loadings on K. Thirty-nine items (38 keyed True, 1 keyed False) that achieved a 75 percent separation between the top and bottom 10 percent of the distribution of a preliminary scale (G; Meehl & Hathaway, 1946) of both of two groups of male VA patients were chosen for the scale that Welsh called A for Anxiety. A became, and remains, the most widely acknowledged marker for the first factor of the MMPI/MMPI-2.

The great response style debate that raged in the decade from 1955 to 1965 was largely concerned with whether the first factor of the MMPI should have a substantive (psychopathologic) or stylistic (test-taking attitude) interpretation. Although this controversy was never fully resolved, it cooled rapidly after Block (1965) demonstrated that even when the two main stylistic features of MMPI performance (social desirability and acquiescence) were controlled, the first and second factors of the MMPI continued to be associated with highly meaningful external correlates.

Among the clinical scales, the best marker for the first factor is Scale 7 (Pt). It is, therefore, instructive to compare A with Pt. Pt is about 20 percent longer than A; the two scales overlap by 13 items, or one third of A. Of these, the content of five items is depressive, three are anxious, two are obsessive, two suggest interpersonal aversion, and one admits problems in concentration. Examining the scale as a whole, A overlaps DEP by nine items (four from DEP2), ANX by seven, and OBS by five. A overlaps Scale 8 (Sc) by eight items, five of which are from subscale Sc4 (Lack of Ego Mastery, Conative). Thus, the content of A emphasizes disturbed concentration and decision making, as well as dysphoria, anxiety, and worry. Other content emphasizes fatigue, discouragement, and lack of initiative; inadequacy, inferiority, and sensitivity; and a sense of deviance and isolation. All of the items are obvious and socially undesirable. Despite its age and the particular circumstances of its development, A remains an excellent marker for the first factor. For example, it correlates at .98 with the 72 items of JBW72 (see Nichols, 2006), the set of items common to the first factor found in the replicated principal components analysis of the MMPI item pool (Johnson et al., 1984; $Ns = 5,506$ and $5,632$), and replicated in turn by Waller (1999; $N = 28,390$), among the combined 25 samples reported by Rouse, Greene, Butcher, Nichols, and Williams (2008; $N = 83,162$).

The empirical correlates for high A scorers among the Graham et al. (1999) outpatients tend to confirm the description given above, but suggested relatively severe symptomatology, with many of these patients having histories of previous psychiatric hospitalizations. They presented with multiple symptoms of depression and anxiety, and were seen as sad, depressed, insecure, hopeless, self-degrading, and with suicidal ideation. In their sample of normal adults, Hoffman and Pietrzak (2012) found Adjective Check List (ACL; Gough & Heilbrun, 1983) correlates that emphasized nervousness, anxiety, worrying, confusion, immaturity, and pessimism (all $> .35$).

Evaluation of the discriminative validity of scales developed for assessing distress syndromes must take the first factor into account, as this source of variance can readily create an appearance of validity in single-group comparisons. Provided that one group is more distressed than another, no matter what the exact phenomenological coloring of the distress in question (whether anxious, depressed, panicky, etc.), such scales will virtually always show evidence of convergent validity. That is, scales of this kind will evidence sensitivity to distress as such but will lack the specificity to discriminate one form of distress from another.

As the major marker for the first factor of the MMPI-2, A plays an important dynamic role in determining the pattern of test findings. Among the basic clinical and validity scales, elevations on A tend to suppress K (and therefore the raw amounts of K added as corrections for five of the eight basic clinical scales), increase positive profile slope, and increase the probability that Scales 7 and especially 8 will figure in the code pattern. A elevations also exert widespread pressure on the content scales to enter the range above T-65, with its heaviest influence on NX, OBS, DEP, LSE, WRK, and TRT. Among the supplementary scales, A tends to exert positive pressure on Mt, PK, PS, and Ho, and negative pressure on GM. The major interpretive significance of high A scores is that the respondent readily admits distress and maladjustment. Duckworth and Anderson (1986) asserted that A reflects short-term, situational (state) anxiety, in contrast to Pt, which they believed represents long-term, characterological (or trait) anxiety. Although their distinction is intriguing and worthy of investigation, the higher test-retest stabilities of A items, relative to those of Pt, would argue against overconfident reliance on this hypothesis. On the other hand, as Duckworth and Anderson point out, the two scales show important differences in item content. The overlap between Scales 7 and 8 at 17 items is greater than that between Scale 7 and A, and more than twice that between Scale 8 and A. This alone would suggest a tilt toward a trait interpretation of Scale 7 relative to A. The content of Scale 7 carries a greater emphasis on ingrained, global personal defects, such as feeling useless, lacking self-confidence, and being incapable. It also implicates more severe cognitive disruption, including problems with memory and comprehension, and fears of losing mental control, over and above the problems with concentration and indecision noted for A. The content on Scale 7 reflecting acute emotional instability and irrational fearfulness is entirely absent from A. Finally, the word worry (-ied, -ing) appears three times on A but only once on Scale 7, whereas anxiety (-ious) appears twice on Scale 7 but only once on A.

Regardless of the merits of assigning A and Pt state and trait implications, respectively, Caldwell (1988) cautioned that differences in their elevations may be confounded by the K correction for Pt. Thus, in comparing the scores on these two scales, it is recommended that A be compared only with the non-K-corrected version of Pt. However, because A has fewer items and is less positively skewed than Scale 7, it tops out about 10 T-score points lower than Pt. For example, the endorsement of two thirds of the items on both scales results in T-scores of about 78 on Scale 7

but only about 70 on A, with this difference increasing slightly as the proportion of the items endorsed on both scales increases. For this reason, especially when K is not too far below the average range, the interpretation of A may be undertaken confidently at somewhat lower levels of elevation than Scale 7, and protocols in which A exceeds Scale 7 (usually in association with elevations on Scale 0) may have particular significance.

In general, high A scorers may be described as uncomfortable, unhappy, and apprehensive. The anxiety they experience appears to be directed more toward a sense of their own incompetence than toward a sense of external threat. Their worry over the adequacy of their performances renders them hesitant, distractible, and vacillating, and this in turn makes them subject to the influence and suggestion of others. Under stress, they tend to become confused, disorganized, and maladaptive. They cope with their feelings of inadequacy by being cautious, standing off, maintaining their distance, avoiding initiative and involvement, and inhibiting action. In interaction with others, they tend to be timid, awkward, passive, and easily rattled.

Provided that the pattern of validity indicators is not overly defensive, low A scorers may be described as showing confidence in their abilities, comfortable and friendly, expressive and assertive, taking initiative, active and readily involved, vigorous and forceful, versatile and achieving. In some cases, low A scorers are better described as egocentric, ostentatious, overconfident, outspoken, competitive, overbearing, manipulative, reckless, and impulsive.

The items for Welsh's R were selected by comparing the top and bottom 10 percent of the distribution of scores on Scale 2. Forty items that achieved separations of 60 percent or more in both VA patient groups comprise R (3 of these were dropped in the transition to MMPI-2; the remaining 37 are all keyed False). Despite marking the second major source of variation among the standard validity and clinical scales of the MMPI/ MMPI-2, R achieves no better than moderate correlations with any of these scales. Its highest correlations are with Scales 2 and 9, at .30 to .40 and at $-.40$ to $-.45$, respectively. Correlations in the range of .30 to .40 are also seen for L, K, and Scale 0. Notable item overlap occurs with Scales 2 (10 items [D-O, six items; D-S, four items]) and 0 (eight items).

The content of R is fairly heterogeneous, including poor health and physical symptoms; inhibited if not blunted emotionality, particularly with respect to "negative" feelings and feelings of energy and excitement; a lack of enjoyment in and under-responsiveness to the potential stimulation of group membership and social interaction; the avoidance of conflict, competition, and social visibility; and a denial of activities and interest in pursuits that may occasion fatigue or stimulation. Taken as a whole, the content of R suggests the suppression of emotionality and the avoidance of interactions with the human and nonhuman environment that may stimulate feeling, whether positive or negative, with the tendency to refer such feeling, when it occurs, to events in the somatic sphere.

Although R scores have been available for more than 40 years, surprisingly little is known of the interpretive significance of high and low scores. Interpretations tend to converge on some notion of control. In his choice of Repression as the designation for R, Welsh (1956) evidently favored a construct believed to operate in an unconscious fashion. Welsh based his choice on the kinds of mental disorders associated with high and low scores on R: "The disorders exhibited by high R scorers are characterized by repression and denial; low R accompanies externalized and 'acting-out' behavior" (p. 280). More recent commentators have tended to reject the unconscious implications of Welsh's construct in favor of a kind of emotional control that is seen to operate within awareness. Thus, Duckworth and Anderson (1986, p. 245) refer to R as "a conscious repression scale (or suppression scale to be more accurate)" that reflects a coping style emphasizing limited insight, (conscious) denial and rationalization, and decisions to limit self-disclosure. Similarly, Caldwell (1988) favored an interpretation of R as constriction, in which the person's "range of feelings is limited and whose emotional responsiveness is constricted across a wide spectrum" (p. 76).

As noted by Nichols and Greene (1995), a comparison of the pattern of MMPI/MMPI-2 scale correlates with R and EC-5 (Ego Control), Block's (1965) second-factor scale suggests an alternative but related interpretation of R. Whereas the correlates of EC-5 suggest the modulation and containment of impulse and aggression, a narrowing of interests, and a deliberate, conforming, prosocial, and risk-averse approach to decision making and behavioral expression, the correlates of R appear to reflect a more central locus of inhibition, one related to the strength of impulse and emotionality, and to openness to experience. Specifically, the high R scorer appears to be one who is uncomfortable with more than minimal levels of stimulation and emotionality, and who therefore prefers to operate in circumstances that are conventional, predictable, familiar, and overlearned. Such preferences, in turn, suggest limitations in the individual's capacity to become aware of, identify, differentiate, and reflect on feelings and other emotional phenomena, and it is this that is the basis for the person's constricted expression of emotionality.

By contrast, low R scores suggest a ready access to feeling and impulse even if not impulsively expressed; an openness to experiencing them; a prodigal and unstable pattern of interests; a high tolerance for stimulation; a willingness to entertain unfamiliar or unconventional points of view; and an ability to tolerate ambiguity, uncertainty, and conflict. Extremely low scores may be associated with chaotic emotionality, in which the individual feels flooded with emotionality or even euphoria, and is overinclusive and indiscriminate in his or her approach to expression.

Graham et al. (1999) reported only somatic symptoms and health preoccupation as broad empirical correlates of high R scores among their psychiatric outpatients. The normal adult ACL correlates found by Hoffman and Pietrzak (2012) included tough, show-off, flirtatious, hard-headed, daring, aggressive, loud, sly, and sociable (all $-.25$ to $-.35$).

Es–Ego Strength

- developed to assess whether a person is likely to respond well to therapy
- empirically derived
 - 17 clients who had clearly improved in therapy were compared to 16 clients who were unimproved
- used to assess ability to manage stressful situations and adaptability
- 52 items
- may be redundant with Pt Scale

T-Scores > 65 are indicative of persons who:

1. are stable, reliable, resourceful and tolerant
2. can tolerate confrontation within the therapy setting

T-Scores < 40 are indicative of persons who:

1. have low self-esteem and poor self concept
2. have difficulties managing daily affairs
3. are withdrawn, inhibited and mild mannered
4. have good treatment intentions but do not act on them
5. have a poor prognosis for therapy outcome

Supplemental Scales: *Ego Strength (Es)*

Items: 52; 20 keyed *True*

Major Internal Correlates: Negatively with scales 1, 2, 7, and 8, *D1, D4, D-O, Hy3, Hy4, Hy-O, Sc3, Sc6, ANX, DEP, HEA, WRK, RCd, RC1, RC7, A, Mt, PK, PS* and, positively, with *GM*.

Most Useful Comparisons: Scales *A* and *K*. The interpretation of *Es* may be complicated by its covariation with the First Factor, such that *Es* and other scales having substantial First Factor variance may be mutually affected. In psychiatric populations and among persons seeking mental health consultation, correlations between *Es* and *K* are commonly in a range of .50 to .60. Thus, high (or low) scores on one of these scales will tend to push scores on the other up (or down). As a result, a relatively low score on *K* when *Es* is substantially higher may lead to an underestimate of stress tolerance and adaptive functioning. Conversely, a relatively high *K* score when it substantially exceeds *Es* may reflect either a desire to portray greater adequacy in coping with problems and stresses than is justified, or depleted and precarious coping resources, or both.

Description: Developed by Barron (1953) as a prognostic indicator for insight-oriented psychodynamic psychotherapy with “psychoneurotic” outpatients, items reflect physical functioning and physiological stability, psychasthenia and seclusiveness, personal adequacy/ability to cope, moral posture, sense of reality, and phobias/infantile anxieties. It appears to function as an indicator of control, organization, and resiliency under stress, and hence of stress tolerance. This scale is discussed more extensively in Friedman et al. (2001).

Interpretation: High scorers have been characteristically described as resourceful, independent, and self-reliant; possessing discipline and determination; showing initiative, flexibility, and tolerance; and as impressing others as being competent and capable and being easily accepted by them. At times they may be seen as aggressive, outspoken, and nonconforming if not rebellious toward authority. Thus they would seem to be able to use psychotherapy to supplement their own problem-solving resources and to tolerate the self-scrutiny and confrontation that often occurs in this form of treatment without becoming upset.

Little is known about the characteristics of patients (or others) who obtain very high scores (i.e., greater than *T*-75), but Gottesman (1959) suggested, based on a review of several normal, delinquent, and psychiatric adolescent and adult samples, that unusually high scores may not reflect the aforementioned favorable traits but rather be achieved by either underreporting psychopathology or by personality-disturbed individuals who may be conflict-free but impulsive, such as psychopaths. Low scorers are unstable, overreactive, and subject to confusion in the face of stresses. They may be upset by seemingly minor matters; less tolerant of other people, despite being suggestible and dependent; inhibited, indecisive, and procrastinating; and more rigid in their outlooks, choices of action, and approaches to problems.

Rather early in MMPI history, clinical researchers saw promise in using the MMPI for predicting a client's response to psychological treatment and for determining which personality characteristics lead to treatment success or end in treatment failure. One interesting attempt to develop a specific scale to measure personality characteristics associated with a successful outcome in therapy resulted in the construction of the Ego Strength (Es) scale. The Es scale was developed by Barron (1953) to help predict whether an individual is likely to respond well to therapy. The Es scale was developed by empirical scale construction procedures. Barron divided a sample of 33 patients into 17 patients who had been judged by their therapists to have clearly improved and 16 who were judged to be unimproved. The test responses of the patients were obtained before the therapy had begun. The scale was proposed as a pretreatment measure of prognosis for therapy. As the Es scale began to be used, and content analysis and intercorrelational studies followed, the meaning of the scale came to be viewed as a measure of adaptability and personal resourcefulness or the ability to manage stressful situations rather than as a predictor of treatment response.

In the revision of the MMPI, the MMPI Restandardization Committee deleted a number of items that were outmoded or objectionable. Sixteen items from the Es scale were among those deleted in the revision; consequently, the MMPI-2 version of Es contains 52 items.

An examination of the content of the Es scale suggests that no single unitary personality dimension is represented by the scale, but it is the sum of a number of complex adjustment factors. The Es scale contains items that can be grouped into the following categories by content: physical functioning and physiological stability; psychasthenia and seclusiveness; moral posture; sense of reality; personal adequacy and ability to cope; phobias; and miscellaneous other content.

In some respects, the Es scale is a measure of problem denial or whether a person is able to manage current stressors. Early correlational research related high scores on the Es scale to such factors as resourcefulness, vitality, self-direction, psychological stability, permissive morality, outgoingness, and spontaneity. High scorers on the Es scale typically show more positive changes in treatment than do low scorers, according to Graham (2006). Graham has summarized the correlates for the Es scale as follows.

A number of personality characteristics have been associated with high and low scores on the Es scale. People with high Es are thought *not* to be experiencing chronic psychopathology and are viewed as more stable, reliable, and responsible than others. They are thought to be alert, energetic, and adventuresome in their approach to life. They are considered to be tolerant in their views of others and to lack prejudice. They show a high degree of self-confidence and may be outspoken and sociable. Individuals with high scores on Es are thought to be resourceful, independent, and grounded in reality. Socially, they are thought to be effective in dealing with others and easily gain

social acceptance. Individuals with high Es scores often seek help because of situational problems. They can usually manage verbal interchange and confrontation in psychotherapy without deteriorating psychologically. They can usually tolerate confrontations in therapy.

Individuals who score low on the Es scale are considered to have low self-esteem and a poor self-concept. They tend to feel worthless and helpless and have difficulty managing daily affairs. In an interview they may appear confused and disorganized and are likely to have a wide range of psychological symptoms, such as chronic physical complaints, chronic fatigue, fears, or phobias. They are likely to appear withdrawn, seclusive, overly inhibited, rigid, and moralistic. They are often seen by the therapist as maladaptive, unoriginal, and stereotyped in behavior. They are likely to demonstrate exaggerated problems or a “cry for help,” have work problems, and show more susceptibility to experiencing day-to-day crises. Their problems are more likely to be viewed as characterological rather than situational in nature. They are likely to express a desire for psychotherapy and feel the need to resolve their many problems; however, it may be difficult for them to focus on problems. Readers interested in a more extensive discussion of the Es scale should see Graham (2006).

Problems in Interpreting the Es Scale in Treatment Planning

Although the Es scale provides the clinician with a measure of the patient's adjustment level and ability to cope with life stressors, it does not fulfill the original hope of being a predictor of treatment amenability that one could use in pretreatment evaluation to appraise potential treatment success. As an index of adjustment, it appears to be a redundant measure of general maladjustment measures, of which there are several in the MMPI-2, such as the Pt scale.

One difficulty in using the Es scale in clinical interpretation is that the scale contains a generally heterogeneous group of items, making substantive interpretation difficult. Several items on the Es scale have little content relevance to treatment prediction. These items were probably included on the scale as a result of chance, since the original scale construction used small sample sizes. For example, in the original MMPI the item “I like Lincoln better than Washington” has neither appropriate content nor empirical validity for the construct being assessed.

The most useful interpretations for the Es scale in treatment prediction were noted by Graham (2006). Graham pointed out, for example, that those who score high on the Es scale typically are better adjusted psychologically and are more able to cope with problems and stresses in their lives. Moreover, he pointed out that high scores on the Es

scale indicate persons who have fewer and less severe symptoms and tend to lack chronic psychopathology. They usually are stable, reliable, and responsible; are tolerant and lack prejudice; and are alert, energetic, and adventuresome. They tend to be sensation seekers who are determined and persistent and may be opportunistic and manipulative. They usually are self-confident, outspoken, and sociable, deal effectively with others, and tend to create favorable initial impressions. Graham also noted that high-*Es* clients tend to seek help because of situational problems and can usually tolerate confrontations in psychotherapy. (For further discussion see Graham, 2006, pp. 182–185.)

In summary, people with low *Es* scores do not seem to be very well put together. Such individuals are likely to be seriously maladjusted psychologically. Problems are likely to be longstanding in nature; personal resources for coping with problems are extremely limited; and the progress for positive change in psychotherapy is poor. Graham (2006) also noted that low *Es* responders do not seem to have many psychological resources for coping with stress, and the prognosis for change in treatment for these persons is not very positive.

Ego Strength Scale (*Es*)

Barron's (1953) Ego Strength scale was the product of an effort to predict the response of "psychoneurotic" outpatients to psychotherapy over a six-month period. The 68 items that discriminated the 17 patients who improved ($M = 52.7$) from the 16 who did not ($M = 29.1$) became *Es*, and these items were subdivided by Barron into eight groups based upon their content: physical functioning and physiological stability (11 items), psychasthenia and seclusiveness (10), attitudes toward religion (6), moral posture (11), sense of reality (8), personal adequacy/ability to cope (11), phobias/infantile anxieties (5), and miscellaneous (6). In the transition to the MMPI-2, *Es* lost 16 items, distributed across the above groups, respectively, as follows: 1, 1, 5, 3, 1, 2, 0, and 3. Thirty-two of the 52 items are keyed False, 20 True. Although neither the therapists nor the type of therapy received by the patients in Barron's sample was adequately described, others have characterized the treatment as psychoanalytically oriented (e.g. Dahlstrom et al., 1975; Graham, 1990). Because this form of therapy often places rather high intellectual demands on its patients, it is notable that Barron found moderate but consistent correlations between *Es* and intelligence across a wide variety of measures. This confounding may in part help to account for the highly mixed character of the results of subsequent validity studies of *Es*. As Greene (2011) noted, "Various studies have reported positive, no, and inverse relationships between the *Es* scale and outcome in psychotherapy" (p. 282). It is also notable that moderate to high correlations between *Es* and various measures of the first factor (e.g. *A* and *K*) have consistently been reported, raising the question of possible differences in initial severity of psychopathology between

patients showing different therapeutic outcomes. In this context, Butcher et al. (1989) reported small but significant negative

correlations between *Es* and the total number of recent life changes and scores on the Social Readjustment Rating Scale (Holmes & Rahe, 1967). These data are consistent with the interpretation that if patients with high *Es* scores show greater improvement in insight-oriented psychotherapy, they do so in part because they are more intelligent and less disturbed than patients who score low. An underappreciated part of the literature on *Es* has examined physiological stability in response to stress (Alexander, Roessler, & Greenfield, 1963; Greenfield, Alexander, & Roessler, 1963; Greenfield, Roessler, & Crosley, 1959; Roessler, Alexander, & Greenfield, 1963; Roessler, Burch, & Childers, 1966; Roessler, Burch, & Mefford, 1967; Roessler & Collins, 1970; Roessler, Greenfield, & Alexander, 1964). Using dependent measures such as catecholamine excretion, finger blood volume, heart rate, muscle potential, and skin resistance, these investigators found that participants having high *Es* scores showed evidence of greater physiological organization in their responses to stressful events than did low *Es* scorers. In the physiological reactions of these participants, there was greater evidence of the preservation of hierarchical organization (“defense in depth”), with more peripheral reactions preceding in an orderly fashion those responses more appropriate for stresses of greater severity. They also showed greater speeds of recovery following the cessation of stress. The responses of low *Es* participants were more chaotic and extreme, with a loss of hierarchical patterning and delayed recoveries. These findings suggest that the more favorable psychotherapy outcomes seen in high *Es* patients may be rooted in the greater integrity of their physiological adaptation to life stresses such that they are better able to avoid overreaction and recover more readily from stresses and setbacks. By contrast, the coping styles of low *Es* scorers would appear to be encumbered by a lack of organization and a vulnerability to overreaction, leading to distracted attempts to assess the sources and meanings of stressors, and rigid or poorly focused attempts at adaptation.

In summary, *Es* appears to serve as a measure of both control and resiliency, factors that would seem to predict successful adaptation even in the midst of significant distress. In this sense, *Es* may serve as an index of *stress tolerance*, and this may be, as Caldwell (1988) suggested, a more valuable focus for interpretive efforts than prognosis for psychotherapy. High *Es* scorers have been characteristically described as resourceful, independent, and self-reliant; as possessed of discipline and determination; as showing initiative, flexibility, and tolerance; and as creating an impression of competence and ability in others and being easily accepted by them. At times, they may be seen as aggressive, outspoken, and nonconforming if not rebellious toward authority. Thus, they would seem to be able to use psychotherapy to supplement their own problem-solving resources and to tolerate the self-scrutiny and confrontation that often occurs in this form of treatment without becoming upset or disorganized. Low *Es* scorers are unstable, over-reactive, and subject to confusion in the face of stresses; may be upset by seemingly minor matters; are less tolerant of other people, despite being suggestible and dependent; are inhibited, indecisive, and

procrastinating; and are more rigid in their outlooks, in their choices of action, and in their approaches to problems. Graham et al. (1999) found that their low *Es* outpatients manifested an especially broad range of psychiatric symptoms, including depression, somatization, and psychoticism. They often had previous psychiatric hospitalizations, and were seen as insecure, hopeless, pessimistic, unambitious, and coping poorly with stress. The women often had histories of physical and sexual abuse, and of suicide attempts. In their normal adult sample, Hoffman and Pietrzak (2012) report ACL correlates suggesting that the high *Es* scorer is calm, clearheaded, ambitious, cheerful, at ease, mature, sociable, optimistic, prudent, attentive, and non-apprehensive. As noted earlier, the interpretation of *Es* may be complicated by its co-variation with the first factor, such that *Es* and other scales having substantial first-factor variance may be mutually affected. For example, in psychiatric populations and among persons seeking mental health consultation, correlations between *Es* and *K* are commonly in a range of .50 to .60. Thus, high (low) scores on one of these scales will tend to push scores on the other up (down). As a result, a relatively low *K* score when the *Es* score is substantially higher may lead to an underestimate of stress tolerance and adaptive functioning. Conversely, a relatively high *K* score when it substantially exceeds the *Es* score may reflect a desire to portray greater adequacy in coping with problems and stresses than is justified, depleted and precarious coping resources, or both. Caldwell (1988) suggested that differences between *Es* and *K* of 10 or more *T*-score points may call for interpretive adjustments along the lines given here.

The ego-strength scale seems to be one of the best indicators of psychological health on the MMPI. The higher the *Es* scale, the more likely the person is to be able to bounce back from problems without becoming debilitated by them. The lower the *Es* scale, the more likely the person is to have difficulty coping with his/her problems. This scale, then, seems to be a measure of ego-resiliency.

The lower the *Es* scale, the more worthless the person usually feels. When the score is below a *T* of 30, the person may be having some problems connected with employment. He/she may be unable to hold a job at this time because of feelings of worthlessness.

Besides measuring the actual ability to bounce back from problems, the *Es* scale may occasionally measure how much a person feels he/she can recover from problems without measuring the actual ability to do so. Obviously, determining whether or not this second interpretation rather than the first one is true for a client is important in order to treat him/her most adequately.

Some other characteristics also may exist with an elevated *Es* scale which usually would not be interpreted as positive. In another study, Barron (1956) found that high scorers sometimes had higher than average aggression and hostility. Further investigation showed that this was related to how pathological their early childhood was. Those who had the most difficulty as children were the most likely to be hostile as adults. That is, a high score on *Es* may show poor

contingent on hostility along with general ego strength if the individual has had childhood experiences characterized by friction in the home, poor relations with his parents, or a mother lacking in emotional warmth. Low scores on the Es scale did not always present a consistent picture in the way people handled hostility; but, in general, they were submissive, rigid, and unadaptive.

Crumpton, Cantor, and Batiste (1960) did a factor analysis of the ego strength scale. The five most important factors would suggest that a reconsideration of the label might be needed. Factors 1, 4, and 5 seem to be related to absence of symptoms or denial of symptoms. Factor 1 was associated with the absence of physical symptomatology and phobic behavior. Factor 4 was the absence of symptoms related to anxiety, rumination, and distractibility; and factor 5 seemed to be the denial of weakness in the face of distress. Factor 2 was related to moderate religious interests, such as attending church but the avoidance of more fundamentalist beliefs or behaviors. Factor 3 was correlated with lack of rebelliousness.

The authors feel on the basis of this factor analysis that what is being measured is the absence of specific ego weaknesses and not the presence of ego strength.

Dahlstrom and Welsh (1960) seem to feel on the other hand that ego strength is probably the best measure of personality control that we have on the test and it probably should be used in this vein.

GENERAL INFORMATION

- 1) The Es scale of 68 items measures physiological stability and good health, a strong sense of reality, feelings of personal adequacy and vitality, and spontaneity and intelligence (Barron, 1953).
- 2) Barron (1953) developed the FA scale to differentiate those individuals who showed a greater degree of improvement after psychotherapy from individuals with similar problems who did not improve. Some studies (Fowler, Ted. & Coyle, 1967; Getter & Sundland, 1962) have found that the Es scores are unrelated to changes in treatment progress. These studies used change after hospitalization to measure the Es predictability however, instead of the change after psychotherapy that Barron (1953) used.
- 3) The Es scale elevation may show the length of time therapy will be needed by the client. The lower the Es the longer the client/patient will need therapy. One study of nonschizophrenic inpatients (Young et al., 1980) has found that the higher the Es scale the shorter the hospital stay.
- 4) The Es scale seems to be a measure of ego-resiliency; that is, the ability to recover from environmental pressures and problems.
- 5) Crumpton et al (1950) have suggested in one study that what is measured by the Es scale is the absence of specific ego weaknesses and not the presence of ego strength.

- 6) While the Es score originally was developed as an index of prognosis in therapy, it also can be used as a criterion of improvement in therapy. That is, people in therapy originally may have low Fs scores, but with psychological improvement the Es scores tend to rise. Abnormally low Es scores may result from a large number of unanswered items (see the 7 scale score) giving the impression erroneously of greater "ego weakness" than may be present (Dahlstrom et al., 1972).
- 7) The Es scale has high negative correlations with scales 2 (-.51), 3 (-.51), 4 (-.68), 5 (-.61), 6 (-.64), and 7 (-.53) for a group of normal people (See Appendix C.). The Es scale has high positive correlations with 8 (.60) and 9 (.54) for the same group.
- 8) Among normals, the Fs scale seems to measure an underlying belief in self-adequacy along with a tolerant, balanced attitude (Harmon, 1980).
- 9) Arnold (1970) has found that marital conflict is more likely to occur if the Ego-Strength scores for the couple are below 50 or if a difference exists of more than 15 points between the two T-scores.
- 10) Heppner and Anderson (1985) have found that self-appraised ineffective problem solvers tend to be significantly lower than effective problem solvers on this scale.
- 11) A shortened form (50 items) of the Es scale has been proposed (Canter, 1965). It was found essentially equivalent to the longer form (68 items) in a separate study (Gravitz, 1970a).
- 12) Women tend to score lower than men on Es. This difference may be because of sex related items (MMPI booklet No. 140, 153, 174, 187, 261, 488, 510, 548). When these items were removed in one study (Holmes, 1967), male and female differences on Es were cancelled out, but the predictive effect of Es in regard to psychotherapy was not affected.
- 13) The Es scale is positively related to intelligence and to education (Tamkin & Klett, 1957).
- 14) Some studies (Tamkin & Klett, 1957) have found no correlation between age and Es score, but others (Getter & Sundland, 1962) have found that older people tend to have lower Es scores.
- 15) The Es scores for college students average between 55 and 65 (Anderson & Duckworth, 1969).
- 16) For individuals in a weight reductions program, Es was positively correlated, .43, with weight loss (Wadden, 1980).
- 17) Barron's original article proposing this scale is in the Basic Readings on the MMPI in Psychology and Medicine (Welsh & Dahlstrom, 1956).

Case History: The Value of Using the Es Scale in Treatment Planning

Sybil, is a 37-year-old single woman who lives with her parents. Her father is a semi-invalid but financially well-off retired businessman. Her mother, a successful attorney and partner in a large law firm, travels a great deal on business. Sybil was a rather reclusive woman with a substantial history of mental illness. She has been hospitalized on three occasions for depression and in each instance improved to the point that she could resume her limited activities. She did not finish college because of an early and seemingly poorly planned marriage. Her husband left town after 6 months without telling anyone where he was going. After several years, with her parents' prompting, she obtained an annulment of her marriage. She has not dated anyone since her husband left.

Her MMPI profile (an extremely elevated 28) shows severe psychopathology. She appears to be quite depressed at the present testing and has problems with her thinking and emotions. She is confused and disorganized and has been experiencing auditory hallucinations. She is also experiencing intense moods that are characterized by anger and despair. She shows some suicidal preoccupation. In the past, she has attempted to kill herself on two occasions. Her poor prognosis for outpatient, insight-oriented psychological treatment is shown by her extremely low score on the Es scale (T = 35). Her Es score suggests that she has a very poor self-concept and low morale, is confused and fearful, and has chronic problems.

HIGH SCORES (T = 55 or Above)

- High scores usually indicate an ability to deal with environmental pressures.
- Occasionally, high scores are indications that people feel they can deal adequately with pressures when they really cannot.

Dahlstrom et al. (1975) have suggested that when a person has a high Es score and is having problems shown by Clinical scale elevations above 70 but is denying them, the high Es score may not be indicating a favorable response to treatment. If the person, however, has a high Es score and admits to having difficulties, the Es score probably indicates a favorable response to treatment.

- A person with a high score generally can profit from psychotherapy.
- People with Es scores in this range can be confronted in therapy without falling apart psychologically.

- The high score indicates that the person may be able to work within the cultural, social, and personal limits of his/her society.
- A high score may indicate that a person can deal effectively with others, gain their acceptance, and create favorable impressions on them.
- Anderson and Kuncze (1984) have found that for clients who have markedly elevated 8 scale scores, elevations on Es and Cn scales may indicate those who are aware of pathological feelings and their potential for acting out impulsively, but their conscious awareness (Cn) and adequate level of ego strength (Es) may enable them to better control their behavior.
- High scores tend to be typical of college students. The usual score for such students is near 60 (Anderson & Duckworth, 1969).

LOW SCORES (T = 45 or Below)

- Low scores may indicate less self-restraint and environmental mastery than average scores do.
- The person with a score in this range frequently perceives situations as stressful when others do not. Therefore, he/she is chronically under more stress than the person with a high Es score.
- Occasionally, low scores are indications that people feel they cannot deal adequately with problems when they really can.
- Low scores may occur when the person is feeling he/she needs help in therapy (the "cry for help" syndrome). A person who feels this way typically has a high F score as well as the low Es score.

- Extraordinarily low scores (T30 or below) usually indicate real or imagined poor work records and an inability to cope with every-day occurrences.
- Cernovsky (1984) has found in one study that alcohol use was related to the average profile elevation of the Clinical scales more clearly for people with low Es scores than for those with high Es scores. In other words, those people with high average profiles and low Es were more likely to have alcohol abuse than those people with high average profiles and high Es scores.
- In one study, self-appraised ineffective problem solvers were significantly lower on Es (Heppner & Anderson, 1985).

COMBINATIONS

Es-Do-St (T = 55 or Above)

This combination tends to be typical of college students and well-adjusted individuals.

Es-Do-St (T = 45 or Below) plus Dy (T = 55 or Above)

These people feel they are not worth much and do not expect much out of life. They also feel they must rely on others to make decisions for them.

SUMMARY OF Es SCALE INTERPRETATIONS

<i>T Score</i>	<i>Interpretations</i>
<i>30 or below</i>	<p>A person with this score tends to have a very poor self-concept and usually feels helpless to act in bettering his/her situation.</p> <p>This person often frustrates the counselor by having good intentions but not</p>

	<p>acting on them. The person usually has a poor work record. Prognosis for successful employment at this time is poor.</p>
<i>30 thru 45</i>	<p>This person tends to have a poor self-concept, is unable to face challenges at this time, and usually is devastated by even minor setbacks.</p> <p>The person needs ego building before he/she is able to deal with problems.</p>
<i>45 thru 60</i>	<p>This person usually has enough ego strength to deal with life's stresses and minor setbacks.</p> <p>For a college student, an Es score in the lower part of this range (45 through 50) may indicate that he/she is not as confident of his/her abilities as other college students are.</p>
<i>60 or above</i>	<p>This person is or feels that he/she is resilient and able to recover from most setbacks.</p> <p>If a client has emotional difficulties indicated by elevated Clinical scales and recognizes this, he/she usually will make a good response to treatment.</p> <p>If he/she has emotional problems and does not recognize this, the client may not have a favorable response to treatment and indeed maybe resistive to suggestions of the necessity of treatment.</p> <p>The person with high Es usually is able to tolerate confrontation in counseling regardless of his/her response to therapy. This level is typical for college students. Usually, scales 9, Do, and St also are elevated.</p>

Mac-R--MacAndrew Alcoholism-Revised Scale

- developed to predict alcoholism
- compared 200 male alcoholics to 200 non-alcoholics presenting for treatment
- 49 items
- has been expanded to include substance abuse and addictive personalities

T-Scores > 65 are indicative of persons who:

1. may have an addictive personality
2. have a strong likelihood of substance abuse
3. have character flaws that could lead to either social deviance and criminality or alcohol and drug abuse
4. incarcerated criminals tend to have elevated MAC-R scores
5. high scores on this scale are predictive of delinquent activities

T-Scores 55-65 are indicative of:

1. somewhat suggestive of substance abuse
2. however, there are many false positives in this range

T-Scores < 55 are indicative of:

Addiction/Substance Abuse Scales: *MacAndrew Addiction Scale-Revised (MAC-R)*

Items: 49; 38 keyed *True*

Major Internal Correlates: Scale 9, *Pd2*, *Ma-O*, *ANG1*, *CYN2*, *ASP1*, *ASP2*, *AGGR*, *DISC*, *AAS* and, negatively, *D-S*, *Hy5*, *R*, *Re*, *GF*.

Most Useful Comparisons: *AAS*, *R*, *DISC*, and *Pd-O* versus *Pd-S*.

Description: MacAndrew (1965) developed the Alcoholism scale (*MAC*) by comparing the item responses of 200 outpatient alcoholics with those of 200 psychiatric outpatients with problems other than alcoholism. He found that a cutting score of 24 correctly classified about 82% of both his initial and cross-validation samples. In the transition to the MMPI-2, four items (three with religious content) were dropped. Because of the tradition of interpreting *MAC* on the basis of raw scores, these items were replaced with four new items that discriminated alcoholic from nonalcoholic psychiatric patients (McKenna & Butcher, 1987), and the revised scale was designated as *MAC-R*. Gottesman and Prescott (1989) criticized the use of raw cutting scores. Because the base rate for alcoholism in MacAndrew's derivation research (1965) was 50%, his cutting score of 24 is likely to produce an excess of false positives in most clinical and nonclinical settings.

Gottesman and Prescott (1989) identified several groups for which classification on the basis of *MAC* scores is subject to high error rates. The first of these is members of the normal population such as those who may be tested as a part of employment screening or in the course of child custody disputes. For such persons, the use of MacAndrew's recommended cutting score may result in as high as three to six times as many false positives as true positives. The situation for normal women is much worse. Because the base rate for alcoholism among women in the general population is only about half of that for men (roughly 4% vs. 8%), the likelihood that a positive (i.e., a score at or above a cutting score favoring even high specificity, such as 24) will be a true positive may drop to as low as 1 in 14. Gottesman and Prescott's discussion of *MAC* in relation to adolescents and ethnic minorities also suggests caution when applied to these groups. Moreover, manipulating cutting scores to reduce the proportion of false positives can be achieved only by increasing the number of alcoholics who will go undetected. Even in settings with relatively high base rates for alcohol abuse, such as among psychiatric patients or correctional inmates, the development of local cutting scores is recommended to minimize misclassification.

To complicate matters further, Greene (1994) reported that profile configuration also can significantly influence *MAC-R* scores. In his analysis, code patterns dominated by Scales 4, 6, and especially 9 tended to have substantially higher *MAC-R* scores than code patterns dominated by Scales 1, 3, 7, and especially 2. As a result, for example, for any given cutting score, 4-9/9-4 codetypes will be associated with a relatively high false-positive rate, and 2-7/7-2 codetypes with a relatively high false-negative rate. On the other hand, scores below such a cutting score in the first instance, or above it in the second, are significantly more likely to be true negatives and true positives, respectively. Finally, there may be some false-negative cases that the *MAC/MAC-R* scale should miss. MacAndrew (1981) proposed a distinction between two kinds of alcoholics, reflecting "two fundamentally different character orientations" (p. 620). The first he designates as primary alcoholics, those true positives identified by the *MAC*

scale. From these he distinguishes a smaller group of secondary or reactive alcoholics, whom he describes as “neurotics-who-also-happen-to-drink-too-much” (p. 620). The extensive research on *MAC/MAC-R* has indicated that this scale reflects a much broader and more fundamental bipolar personality dimension, such that it may function as a measure of an important risk factor for substance abuse, rather than as an indicator of substance abuse itself.

Several studies (Fowler, 1975; Kranitz, 1972; Lachar, Berman, Grisell, & Schoof, 1976; Rhodes & Chang, 1978; Sutker, Archer, Brantley, & Kilpatrick, 1979) have reported that drug abusers of various kinds (mostly heroin addicts) typically produce scores on the *MAC* in the same range as alcoholics, and Graham (1978) found similar scores in a sample of pathological gamblers. The outpatients studied by Graham et al. (1999) tended to conform in most respects with previous expectations regarding the empirical correlates of high scorers. Their patients, 75% of whom were Caucasian, tended to have long histories of abusing alcohol, marijuana, cocaine, or a combination of these. Although both men and women were seen as antisocial, acting out, and having conflicts with authority, these characteristics appeared especially strong among their women patients, who often had histories of many arrests, misdemeanor and felony convictions, impulsiveness, and a low tolerance for frustration. This cluster of traits is relatively stable over time. Hoffmann, Loper, and Kammeier (1974), for example, compared the MMPIs of 25 male alcoholics in treatment in a state hospital and the MMPIs these patients had completed as entering freshmen at the University of Minnesota. They found no differences in the *MAC* scores of these men, despite an average of 13 years between test administrations. Several studies (Chang, Caldwell, & Moss, 1973; Gallucci, Kay, & Thornby, 1989; Huber & Danahy, 1975; Rohan, 1972; Rohan, Tatro, & Rotman, 1969) have reported that *MAC* scores show no change over the course of treatment or on follow-up. These findings provide yet another reason for interpreting *MAC-R* scores cautiously. The risk of misidentification cannot, in general, be circumvented through the use of such softened locutions as “potential for alcoholism” or “addiction prone,” because such attributions may be equally harmful in their consequences, particularly among normals (e.g., job applicants). Although there is little doubt regarding validity of the *MAC/MAC-R* as a general measure of surgency, the bulk of research on its use for detecting alcoholism or addiction-proneness is equivocal, particularly for populations other than adult white men. Under these circumstances, the use of *MAC* scores for the prediction of substance abuse (or a liability thereto) in the individual case must be undertaken with caution. This scale is discussed more extensively in Friedman et al. (2001). Reviews by Gottesman and Prescott (1989), Graham and Strenger (1988), Greene and Garvin (1988), and MacAndrew (1981) are also recommended for further study.

Interpretation: High scorers are bold and energetic, self-confident and self-assertive, extroverted and sociable, uninhibited and impulsive, pleasure- and sensation-seeking, aggressive, rebellious, and resentful of authority, and

may have been arrested or in trouble with the law. Low scorers are timid, anergic, inhibited, controlled, respectful of authority, and nonaggressive.

Substance abuse Measures:

The MacAndrew Alcoholism Scale (*MAC/MAC-R*);

the Addiction Admission Scale (*AAS*);

and the Addiction Potential Scale (*APS*)

Few scales in the history of the MMPI/MMPI-2 have been the subject of more research investigation than MacAndrew's (1965) Alcoholism scale (*MAC*). This research has been organized and summarized in many reviews (e.g. Allen, 1991; Apfeldorf, 1978; Craig, 2005; Friedman et al., 1989a; Gottesman & Prescott, 1989; Greene, 1994; Graham & Strenger, 1988; Greene & Garvin, 1988; MacAndrew, 1981; Megargee, 1985; Weed, Butcher, & Ben-Porath, 1995; Young & Weed, 2006), to which the reader is referred for more detailed coverage of *MAC/MAC-R*. Several prior attempts to develop a scale for the prediction of alcoholism had been made in the 1950s (Hampton, 1951; Holmes, 1953; Hoyt & Sedlacek, 1958), but their development typically involved comparisons between alcoholics and normals. Because discomfort and disturbance were more frequent in the alcoholic samples, these scales tended to reflect general maladjustment, i.e. to be saturated with nonspecific variance related to the first factor. The method used by MacAndrew (1965) controlled this source of variation. He compared the item responses of 200 alcoholic outpatients with those of 200 psychiatric outpatients with problems other than alcoholism. Differentiating items were then cross-validated on another 100 members of each of these two groups. Fifty-one items survived cross-validation, of which 49 did not include content related to alcohol consumption.

Although the two obvious items provided the best discrimination between his groups, MacAndrew decided not to include them on the final scale because they could be easily dissimulated. He found that a cutting score of 24 correctly classified about 82 percent of both his initial and cross-validation samples. In the transition to the MMPI-2, four items (three with religious content) were dropped. Because of the tradition of interpreting *MAC* on the basis of *raw* scores, these items were replaced with four new items that were found to discriminate alcoholic from nonalcoholic psychiatric patients (McKenna & Butcher, 1987); the revised scale was designated *MAC-R*. Thirty-eight of the items on *MAC-R* are keyed True, 11 False. *MAC-R* shares nine items with *Re* (keyed oppositely) and the Addiction Potential scale (*APS*; see below); eight items each with *Sc* and *Si*, keyed oppositely on both; and six items with *R* and *Do*, likewise keyed oppositely on both. It is moderately correlated with *Re*, *Ma* (non-*K*-corrected), *ASP*, and *DISC* in a range of .50–.55.

The use of raw cutting scores has been tellingly criticized by Gottesman and Prescott (1989). Because the base rate for alcoholism in MacAndrew's (1965) derivation research was 50 percent, his cutting score of 24 is likely to produce an excess of false positives in most clinical and nonclinical settings. For example, in their exhaustive review of studies on *MAC*, Greene and Garvin (1988) reported weighted means for White alcoholic men and women of 28.41 ($SD = 5.45$) and 25.33 ($SD = 4.28$), respectively. The corresponding false negative rates were 20.4 and 46.5, respectively. They reported a weighted average for normal White men, the group from which White adult alcoholic men are most readily discriminated by *MAC*, of 23.13 ($SD = 4.31$), with a false-positive rate of 26.5 percent. For White male psychiatric patients, the comparable figures are 23.30 ($SD = 4.60$), and a false-positive rate of 31.4 percent. The weighted means for both of the latter groups are uncomfortably close to MacAndrew's recommended cutting score. Because the comparable scores for White normal and psychiatric women are about two raw score points below those of White men, their false-positive rate is correspondingly lower—about 20 percent. What little data are available for ethnic minorities suggest that ethnicity can exert a significant influence in the diagnostic efficiency of *MAC*. Wood (2008), for example, found that *MAC-R*, *AAS*, nor *APS* predicted lifetime alcohol or drug dependency in his sample of Native Americans. Greene and Garvin (1988) found a weighted mean score of 26.32 ($SD = 4.86$) for the few available studies involving African American male psychiatric patients; for this group the rate of false positives reached 59.5 percent.

The foregoing values provide an inadequate picture of the ability of *MAC* to identify alcoholic individuals, however. Studies of *MAC* usually involve participant samples the composition of which is widely divergent from the typical base rates seen in both normal and psychiatric settings, when these can be determined at all. Gottesman and Prescott (1989) identified several groups for which classification on the basis of *MAC* scores is subject to large error rates. The first of these is members of the normal population, such as those that may be tested as a part of employment screening or in the course of child custody disputes. For such persons, the use of MacAndrew's (1965) recommended cutting score may result in as many as three to six times as many false as true positives. The situation for normal women is much worse. Because the base rate for alcoholism among women in the general population is only about half of that for men (roughly 4 percent vs. 8 percent), the likelihood that a positive (i.e. a score at or above even a cutting score favoring high specificity, such as 24) will be a *true* positive may drop to as low as 1 in 14. Gottesman and Prescott's discussion of *MAC* in relation to adolescents and ethnic minorities is to similar cautionary effect (e.g. Wood, 2008). Moreover, the manipulation of cutting scores to reduce the proportion of false positives can only be achieved at the cost of increasing the number of alcoholic individuals who will go undetected, i.e. false negatives. Even in settings with relatively high base rates for alcohol abuse, such as among psychiatric patients or correctional inmates, the development of local cutting scores is recommended to minimize misclassification. In settings with relatively high base rates for alcohol abuse, such as among psychiatric patients or correctional inmates, *MAC-R*

scores may inadequately separate substance abusers from non-abusers (e.g. Gripshover & Dacey, 1994). *MAC-R* may likewise perform poorly when base rates are low, as among college students (e.g. Svanum & Ehrmann, 1993), although Svanum, McGrew, and Ehrmann (1994), in a similar sample, found that *AAS* showed a moderate ability to identify substance use disorder, primarily alcoholism, while their findings for *MAC-R* and *APS* were, at best, marginal. These kinds of findings can only emphasize the importance of developing local cutting scores within settings where *MAC-R* is to be given diagnostic weight in order to minimize misclassification rates. To complicate matters further, Greene (1990a) and Archer and Klinefelter (1992) have reported that profile configuration also can significantly influence *MAC-R* scores. In Greene's analysis, code patterns dominated by Scales 4, 6, and especially 9, tended to have substantially higher *MAC-R* scores than code patterns dominated by Scales 1, 3, 7, and especially 2, for reasons that are elaborated later. As a result, for example, for any given cutting score, 49/94 code patterns will be associated with a relatively high false-positive rate and 27/72 code patterns will be associated with a relatively high falsenegative rate. On the other hand, scores below such a cutting score in the first instance, or above it in the second, are significantly more likely to be true negatives and true positives, respectively.

Finally, there may be some false-negative cases that *MAC/MAC-R* *should* miss. MacAndrew (1981) proposed a distinction between two kinds of alcoholism, reflecting "two fundamentally different character orientations" (p. 620). The first he designated as *primary alcoholics*, those true positives identified by *MAC*. From these, he distinguished a much smaller group of *secondary or reactive alcoholics*, whom he characterized as "neurotics-who-also-happen-to-drink-too-much" (p. 620). In a study by Tarter, McBride, Buonpane, and Schneider (1978), the reactive alcoholic group not only scored significantly lower on *MAC* ($M = 23.3$, $SD = 3.1$) than the primary alcoholic group ($M = 28.5$, $SD = 3.7$), they also reported less than half as many relatives with a history of heavy drinking and only one quarter as many symptoms of "minimal brain dysfunction" (accident proneness, lack of popularity with peers, unresponsiveness to discipline, vandalism, short attention span, fidgeting, inability to complete projects, inability to sit still, not working up to ability, ease of frustration, intolerance of delay, demanding of attention/affection, withdrawal, poor handwriting, overactivity, and impulsiveness). MacAndrew's distinction is also supported in the findings of Svanum and Ehrmann (1992) and Ward and Jackson (1990), in which primary alcoholics obtained higher *MAC* scores than secondary alcoholics; in those of Humphrey (1999) in a sample of driving under-the-influence (DUI) offenders; and by those of Knowles and Schroeder (1990) in which undergraduates with a positive family history for alcoholism scored higher than those with a negative family history.

Although 30 years of research have amply attested to the validity of *MAC* for identifying at least so-called primary alcoholics, there has been a steady accumulation of evidence (Allen, Faded, Rawlings, & Miller, 1991; Finney, Smith, Skeeters, & Auvenshine, 1971; Levinson et al., 1990; MacAndrew, 1981) that *MAC* appears to be measuring a much

broad and more fundamental bipolar personality dimension. Recall that because both the alcoholic and comparison groups used by MacAndrew (1965) to derive *MAC* were psychiatric patients, his design may be presumed to have exerted significant control over the influence of first-factor variation. Under these circumstances, the next most pervasive source of variance in the MMPI item pool, the second factor, could have been influential in the separation of his groups. The finding of Schwartz and Graham (1979) that *MAC* was significantly correlated with Wiggins' (1966) Authority Conflict (.61) and Hypomania (.55) content scales, with Welsh's *R* (−.62), and with Scale 9 (.55), all of which typically load on the second factor, confirms this expectation and is consistent with the Greene (1990b) and the Archer and Klinefelter (1992) findings, described earlier, that code pattern influences *MAC-R* scores. Hence, it should not be surprising that whatever variance possessed by *MAC-R* that is specific to the abuse/non-abuse of alcohol is secondary to a personality/life style that constitutes a risk factor for such abuse (see, e.g. Allen, Faden, Rawlings, & Miller, 1991; Earleywine & Finn, 1991; Hoffman & Pietrzak, 2012; Patton, Barnes, & Murray, 1993; Smith & Hilsenroth, 2001). The consensus of the research to date suggests that the high *MAC-R* scorer is characterized as bold and energetic; assertive and self-confident; extraverted and sociable; uninhibited and impulsive; pleasure and sensation seeking; aggressive, rebellious, and resentful of authority; and having been arrested or in trouble with the law. Several studies (Craig, 2005; Fowler, 1975; Kranitz, 1972; Lachar, Berman, Grisell, & Schoof, 1976; Rhodes & Chang, 1978; Sutker, Archer, Brantley, & Kilpatrick, 1979) have reported that drug abusers of various kinds (mostly heroin addicts) typically produce scores on *MAC* in the same range as alcoholics, and Graham (1978) found similar scores in a sample of pathological gamblers. The outpatients studied by Graham et al. (1999) tended to conform in most respects with previous expectations regarding the empirical correlates of high scorers. Their patients, 75 percent of whom were Caucasian, tended to have long histories of abusing alcohol, marijuana, and/or cocaine. Although both men and women were seen as antisocial, acting out, and having conflicts with authority, these characteristics appeared especially strong among their women patients, who often had histories of many arrests, misdemeanor and felony convictions, impulsiveness, and a low tolerance for frustration.

The cluster of traits associated with *MAC/MAC-R* is relatively stable over time. Hoffmann, Loper, and Kammeier (1974), for example, compared the MMPIs of 25 alcoholic men in treatment in a state hospital and the MMPIs these patients had completed as entering freshmen at the University of Minnesota. They found no differences in the *MAC* scores of these men, despite an average of 13 years between test administrations. A number of studies (Chang, Caldwell, & Moss, 1973; Gallucci, Kay, & Thornby, 1989; Huber & Danahy, 1975; Rohan, 1972; Rohan, Tatro, & Rotman, 1969) have reported that *MAC* scores show no change over the course of treatment or on follow-up. These findings, of course, provide yet another reason for caution in the interpretation of *MAC* scores. The risk of misidentification cannot, in general, be circumvented through the use of softened locutions such as “potential for

alcoholism” or “addiction prone,” as such attributions may be equally harmful in their consequences, particularly among normal such as job applicants.

Although there is little doubt of the validity of *MAC/MAC-R* as a general measure of surgency, the bulk of research on its use for the detection of alcoholism or addiction proneness is equivocal, particularly for populations other than adult White men. Under these circumstances, the use of *MAC-R* scores for the prediction of substance abuse (or a liability thereto) in the individual case must be undertaken with caution. Friedman et al. (2001) suggested that the diagnostic efficiency of the scale may be enhanced by seeking support for the implications of *MAC-R* elevations among items with obvious content related to substance abuse, such as those found on the Addiction Admission scale (*AAS*).

Although this suggestion is both plausible and has received some research support (Dwyer, 1996; Stein et al., 1999), such a practice raises the question of the incremental validity of *MAC-R* or any similar scale, i.e. what is *MAC-R*'s (or *APS*'s) role in the prediction of substance abuse if the examinee endorses test items that explicitly admit such abuse? This is a question for future research to address. It is possible, however, that if MacAndrew's (1981) distinction between primary and secondary alcoholism becomes more fully corroborated, *MAC-R* may retain a useful role in the subclassification of alcoholic individuals who endorse item content admitting substance abuse. *MAC/MAC-R* scores may also be used to modify the interpretation of scales such as *Pd* and *Ma*. Because both of the latter scales may be elevated into an interpretable range on the basis of their respective first-factor components, largely *Pd4* (Social Alienation), *Pd5* (Self-Alienation), and *Ma2* (Psychomotor Acceleration), the empirical correlates of *Pd* and *Ma* may not apply, or may apply less strongly, when elevations on these scales are achieved on the basis of items distributed more widely across their subscales. In such cases, reference may be made to *MAC-R* scores, with high scores tending to support the application of the usual correlates associated with these scales and low scores emphasizing aspects of negative emotionality, such as dysphoria, guilt, agitation, and identity concerns. *MAC-R* scores may also moderate the interpretation of many other scales, such as *R*, *O-H*, and varieties of the content scales. Weed et al. (1992) developed two new substance abuse measures, the Addiction Admission scale (*AAS*) and the Addiction Potential scale (*APS*), taking advantage of a wider range of item content related to substance use in the MMPI-2 item pool. *AAS* is a refinement of 14 initial items with content thought to be obviously related to substance abuse. Three of its items were deleted for degrading the internal consistency of the remaining items, and two items were added following a search of the total item pool for items with consistent content that achieved high point-biserial correlations with the 11-item core scale. Ten of the 13 *AAS* items are keyed True, 3 False. Clements and Heintz (2002) found two principal components: acknowledgment of alcohol/drug problems and positive alcohol expectancies.

Weed et al. (1992) reported an internal consistency estimate (coefficient alpha) for *AAS* of .74. Three reports (Dwyer, 1996; Rouse, Butcher, & Miller, 1999; Stein, Graham, Ben-Porath, & McNulty, 1999) provide evidence that *AAS* is superior to *MAC-R* and *APS* in the prediction of substance abuse among dually diagnosed psychiatric patients, private psychotherapy clients, and public mental health outpatients, respectively. For most comparisons across these studies, *AAS* was associated with higher values for sensitivity, specificity, positive predictive power, negative predictive power, and correct classification rate than those for *MAC-R* and *APS* for both women and men. Moreover, they found that the incremental variance that *AAS* brought to predictions of substance abuse was substantial, whereas the incremental validity of the other two scales over *AAS* was modest and, in the case of *APS*, negligible. The correlates of high *AAS* scores among the Graham et al. (1999) outpatients reflected diagnoses and histories of substance abuse for both men and women, but whereas the men were generally seen as depressed, insecure, and intropunitive, the women were described as antisocial, impulsive, argumentative, sarcastic, and cynical.

AAS functions essentially as a critical item list, but with the advantage of scaled scores, to detect substance abuse among persons who are able (insightful) and willing to admit such problems. Although intercorrelated at about .5, there is reason to think that conjoint use of *AAS* and *MAC-R* may be attended by an increase in diagnostic efficiency in the identification of substance abuse among non-psychiatric patients and strong reason to anticipate differences in treatment readiness among substance abusers. When *AAS* is high and *MAC-R* (or *APS*) is unelevated, abuse may be largely situational and therefore carry a highly favorable prognosis. When *AAS* and *MAC-R* (or *APS*) are both elevated, the presence of personality and lifestyle features disposing to substance abuse and the admission of such abuse combine to suggest a less favorable prognosis but a potential readiness to engage in treatment. When *MAC-R* (or *APS*) is high but *AAS* is unelevated, the prognosis for treatment, at least among true positives, may be poorer

because of the person's reluctance to confide substance abuse.

APS would appear to function much as other empirically derived scales, including *MAC-R*. The basic strategy for its development required that potential items discriminate a substance abuse sample from both the MMPI-2 re-standardization sample and a mixed psychiatric sample. Participants from all the samples were subdivided on the basis of gender. Each item was subjected to four comparisons: male substance abusers versus male normals, male substance abusers versus male psychiatric patients, female substance abusers versus female normals, and female substance abusers versus female psychiatric patients. An initial item set comprising 51 items were found significantly discriminating in three of these four comparisons. Ten additional items were added on the grounds that they were strongly discriminating in two of the four comparisons and overlapped the (original) *MAC* scale. Twenty-two items were then discarded because their endorsement frequencies were intermediate to those of normals and psychiatric

patients, their content was obviously related to substance abuse, or they degraded the internal consistency of the remaining items. Like *MAC-R* then, *APS* is subtle in the sense of excluding items with content related to substance abuse like those on *AAS*. On cross-validation, the final 39-item *APS* scale achieved separations of about 1.5 *SD* units in the same four comparisons. In an independent replication, Greene, Weed, Butcher, Arredondo, and Davis (1992) found that *APS* separated substance abusers from psychiatric patients at just under 1 *SD* unit, the shrinkage owing in part to an estimated 10 percent to 20 percent rate of substance abuse in the psychiatric sample. Twenty-three of the *APS* items are keyed True, 16 False. The major content domains of *APS* are suggested in the five principal components (with Varimax rotation) found by Sawrie, Kabat, Dietz, Greene, Arredondo, and Mann (1996) in a sample of 264 alcoholic and 456 psychiatric inpatients: satisfaction/dissatisfaction with self, powerlessness/lack of self-efficacy, antisocial acting-out, surgency, and risk-taking/recklessness. A similar analysis by Clements and Heintz (2002) in a sample of 87 male and 251 female undergraduates substantially corroborated the former findings in four components: satisfaction with self, cynicism/pessimism, impulsivity, and risk-taking.

APS performed better than *MAC-R* in both the Weed et al. (1992) and Greene et al. (1992) studies, particularly among women, but it performed less well than *MAC-R* among the Graham et al. (1999) outpatients. It remains to be seen if any advantage favoring *APS* over *MAC-R* can be extended to the detection of substance abuse problems in patients with comorbid psychiatric disorders. Research is needed on both scales that incorporates the main features of MacAndrew's (1965) design, especially the comparison of alcoholic individuals having comorbid psychiatric disorders with nonalcoholic psychiatric patients. On the whole, however, the research to date (see Clements & Heintz, 2002; Demir, Uluğ, Batur, & Mercan, 2002; Devlin, 1998; Dwyer, 1996; Rostami, Nosratabadi, & Mohammadi, 2007; Rouse, et al., 1999; Stein et al., 1999) suggests that *APS* is the weakest of the three MMPI-2 substance abuse measures.

Further research is also needed to evaluate the personality characteristics of high and low *APS* scorers and the patterns and implications of co-variation between *APS* and other MMPI-2 scales and indexes. Such research would help to illuminate whether, like *MAC-R*, *APS* can be considered a general dimension of personality or is better treated as a measure, the utility of which extends no farther than that anticipated at the time of its construction: a subtle measure of substance abuse.

Mac SCALE (Mac Andrew Addiction Scale)

The Mac Andrew Addiction scale (Mac) was developed by Craig Mac Andrew (1965) originally to differentiate male psychiatric out patients who were in treatment for alcohol abuse from male nonsubstance-abusing psychiatric

outpatients. Fifty-one MMP1 items were identified that made such a differentiation. Two of the 51 items were excluded from the scale (booklet items No. 215 and No. 460) since they were too obvious in asking about alcohol symptoms, leaving 49 items. A cut-off score of 24 and above was used by Mac Andrew to identify alcoholics and this score correctly classified 81.5% of his population.

Since 1965, this 49 item scale has been cross validated many times and with many different populations; VA hospital inpatients (Burke & Marcus, 1977), general hospital inpatients (de Groot & Adamson, 1973), and non-psychiatric outpatients (Lachar et al., 1976; Rhodes, 1969). In these studies and others, again approximately 85% of the alcoholics were correctly identified, whereas 15% of them were classified falsely as non-alcoholic. Mac Andrew (1981) has hypothesized that these 15% false negatives are not primary alcoholics but really "reactive" or secondary alcoholics. He described these people as "neurotics who also happen to drink too much" and believed that they do so to remove themselves from the pain of their daily living.

This is in contrast to the primary alcoholic who is reward-seeking rather than punishment-avoidant as the secondary alcoholic is. Primary alcoholics are described by Finney, Smith, Skeeter, and Suvenshine (1971) as "bold, uninhibited, self-confident, sociable people who mix well with others. They show rebellious urges and resentment of authorities. They tell of carousing, gambling, playing hooky, and generally 'cutting up.' Yet their answers show that they are drawn to religion" (p. 1058). Burke (1983) also saw the Mac scale as a measure of the impulsivity, the pressure for action, and the acting-out potential that lead to alcoholism and probably also to the misuse of other substances.

Female alcoholics also have been studied but much less frequently than male alcoholics. In general, their Mac Andrew scores are lower than the males'. Authors of one study (Svanum et al., 1982) have found 23 and above as the most accurate cut-off score for their population of female alcoholics. In work that Duckworth has done with non-psychiatric clients, she also has found that women in general score lower than men on the Mae scale. The females' average score was 19 whereas the males' average score was 21 (Duckworth, 1983).

After the Mae scale was used with alcoholics for a period of time, drug abusers were tested (Burke & Marcus, 1977; Kranitz, 1972; Lachar et al., 1976; Sutker et al., 1979) and the scale was found to differentiate them from non-drug abusers with approximately the same degree of accuracy as was found in the differentiation of alcoholics from non-alcoholics. The scale accurately classified heroin and poly-drug abusers in these studies; however, Caldwell (1985) has reported that the scale does not pick up cocaine abuse in the populations he had tested (medical center inpatients and outpatients) nor has it differentiated recreational marijuana users in the population with whom the authors work (college students).

In college and mental health settings, the scale may need to be used somewhat differently than it is in a psychiatric population. If people are having trouble with alcohol or drug use, we find the cut-off scores that Mac Andrew and others have used, 24 and above for men, and 23 and above for women, to be useful. However, if people are not having trouble with drinking or drug abuse, we have felt safer in labeling men addictive only when their scores are 27 or above and women when their scores are 25 or above. When men and women score high, most of them recognize the "pull" of alcohol or drugs, but they have not been having problems with addiction because they have worked very hard at controlling themselves. Many of these people seem to be motivated by the "horrible example" of an alcoholic parent or parents, and they use this example to limit their drinking or drug use.

People in college and mental health settings who have scores of 24, 25, or 26 on this scale may also report some of this "pull" of alcohol or drugs, but much less frequently than the people with scores of 27 or more. We also have found many people in this range who have never tried alcohol or drugs because of religious beliefs. Possibly if they did not have those beliefs and had tried drinking and/or drugs, they might indeed be alcoholic or drug abusers. What a low score, below 15 raw score points, means on the Mac-Andrew scale is currently unknown. However, Caldwell has hypothesized (1985) that people scoring 10 raw score points or below cannot tolerate alcohol. People in general score from 15 through 22 raw score points on this scale.

We have found that the score on this scale does not tend to change over time. Duckworth has found that on retesting people after a six month period, the Mac Andrew score typically changed 2 raw score points or less. Indeed, so stable is this scale, that a score has been found not to change with successful treatment for alcoholism (Huber & Danahy, 1975; Rohan et al, 1969; Rohan, 1972; Lanyon et al., 1972). Mac Andrew also has noted (1981) that the Mac scores of alcoholics do not change with treatment or even after prolonged substance abuse. He also found that the Mac scores are not related to age or race. What the scale does seem to measure is a fundamental character dimension. He endorses Finney's (1971) description of the primary alcoholic noted earlier as the personality characteristics measured by elevations on the Mac scale.

Predictive Research on the MAC Scale

There is some disagreement over the extent to which MAC-R is useful in detecting substance abuse problems (see Gottesman & Prescott, 1989; Graham & Strenger, 1988). However, most textbooks recommend the use of the MAC-R in a conservative manner. There is a need to adjust the cutoff scores for both African Americans and women. For example, research has shown that African Americans typically score in the potential alcohol abuse range on the MAC scale and that classification rates are not as good as with white populations (Walters et al., 1983, 1984). In

clinical practice, the ranges listed earlier should be set 2 points higher for minority Americans. Research on the MAC-R shows strong support for its use in detecting substance abuse problems (Craig, 2005; Graham, 1989; Levenson et al., 1990; Smith & Hilsenroth, 2001). Craig (2005) reviewed the existing studies on the MAC/MAC-R across a number of studies totaling almost 32,000 clients, including adolescent and adult substance abusers, from studies published since the last MAC reviews (1989) through 2001. Results suggest that the MAC, and to some extent the MAC-R, significantly correlates with measures of alcohol and substance abuse in both male and female adolescents and adults across a diverse spectrum of the use–abuse continuum. They found that 100% of nonclinical groups scored below the clinical ranges on the MAC/MAC-R, while 79% of adolescent substance-abusing groups scored greater than 23, indicative of problems with substance abuse. Clients who abused alcohol, drugs, and polydrugs had mean MAC/MAC-R scores >23, which ranged from 77% to 100% of the cases. The MAC/MAC-R does well in discriminating persons who abuse substances compared to nonclinical, non-abusing groups. However, some diagnostic efficiency is lost with psychiatric patients and medical patients with seizure disorders. Increasing the cutoff score to greater than 25 improved diagnostic accuracy in these groups. The assessment of substance abuse problems is clearly central to treatment planning. If a new patient has a high MAC-R score, the therapist should be aware of the complications that could occur during therapy when the individual becomes frustrated and acts out with excessive substance abuse.

Another valuable use of the MAC-R score in treatment planning involves application of the finding that a number of patients in treatment for substance abuse (about 15%) have low scores—less than a raw score of 24 for males and 21 for females—when it would be expected that their MAC-R scores would be high. The low MAC-R score typically indicates that a person is experiencing alcohol or drug abuse problems as secondary to other psychological problems, and treatment of the other problems may be necessary to clear up the substance abuse problems.

GENERAL INFORMATION

1. This 49 item scale measures the potential for addiction to alcohol and/or drugs.
2. Schwartz and Graham (1979) factor analyzed the scale and found it measures impulsivity, high energy level, interpersonal shallowness, and general psychological maladjustment.
3. Test-retest reliability is high.
 - a. Scores do not change significantly with successful treatment for addiction.
 - b. Over a 6 month period, Mac scores for subjects did not change significantly (Duckworth, 1983).
4. Schwartz and Graham (1979) have found the scale correlates .55

with scale 9 (impulsivity and energy) and $-.62$ with scale R (repression). In another study of therapy clients (Duckworth, 1983) the scale correlated with K, $-.34$; 9, $.39$; R, $-.38$; Re, $-.50$; and Pr, $.36$.

5. It has not correlated with race in some studies (Lachar et al., 1976;

Page & Bozler, 1982; Uecker et al., 1980), however Walters et al. (1983) found that this scale did not discriminate between Black alcoholics and Black non-alcoholics in an active duty military sample.

6. The scale does not correlate with age (Appledorf & Hunley, 1975;

Friedrich & Loftsgard, 1978; MacAndrew, 1965; Uecker et al., 1980; Duckworth, 1983).

7. The average range of scores for a group of non-addictive normals ($N = 433$) was from 15 through 23 (Duckworth, 1983):

The mean score for women was 19 The mean score for men was 21

8. The scale seems to show discrimination between substance abusers and nonabusers as early as late adolescence (MacAndrew, 1979b).

9. The scale may be predictive of future alcoholism as early as entrance

to college. Hoffman, Loper, and Kammeier (1974) found the mean Mac scale scores of 25 hospitalized alcoholics was not significantly different than their average score at the time of their entrance to college, some 13 years earlier.

10. Suicide prone alcoholics are likely to be those who are using alcohol but not scoring in the addictive range on the scale (MacAndrew, 1981).

11. Craig (1984b) has found that drug addicts with a co-existing alcohol problem have higher Mac scores than addicts without a current alcohol problem.

12. Researchers have found that the scale can be administered as a separate test of 49 items with no significant difference in the Mac score than the score obtained when the scale is administered embedded in the total MMPI (MacAndrew, 1979a; Duckworth, 1983).

13. If the shortened version of Form R has been given (399 or 400 items), the Mac scale can be scored and multiplied by 1.34. This approximates the Mac score which would be obtained if all of the items were answered (Streiner & Miller, 1981).

14. The items making up the Mac scale are located in Appendices A and B.

15. Four items of the scale [Booklet No. 61 (T), 156 (T), 251 (T), and 378 (F)] plus two additional items [No. 215 (1) and 460 (T)] may show how willing the person is to admit to alcoholism since these are very obvious items. Conley and Kammeier (1980) suggest these might be used as a measure of willingness to admit to alcoholism.

16. T-score conversion tables for the Mac scale for men and women are available in the book by Greene (1980).

HIGH SCORES

(24 and Above for Males)

(23 and Above for Females)

1. The cut off scores of 24 and above for men and 23 and above for women work best for people self-referred or brought in by others for substance abuse problems.
2. For people who are having psychological difficulties, but substance abuse is not one of them, scores of 24, 25, and 26 raw score points for men and 23, 24, and 25 raw score points for women may not indicate current substance abuse but a potential for it if psychological pressure should be increased.
 - a. Some people in this range may recognize the "pull" of substance abuse but work hard at controlling it because of the example of an addicted parent.
 - b. Others may have religious beliefs that keep them from using alcohol or drugs.
3. With a raw score of 27 and above for men, and 25 and above for women, most people recognize that they have an addictive potential. The higher the score and the more psychological pressure the person is under, the greater the likelihood that there will be substance abuse.
4. Clopton and Weiner (1980) found 27 and above to be the best cut off score for their sample of psychiatric inpatients.
5. Alcoholics who score in the addictive range on this scale (primary alcoholics) report four times as many symptoms of "brain dysfunction" in childhood as do alcoholics who do not score in the addictive range on the Mac (secondary alcoholics) (Mac Andrew, 1981).

LOW SCORES

(Below 15 Raw Score Points)

- Caldwell (1985) has hypothesized that people who score 10 raw score points or below cannot tolerate alcohol.

Raw Score Interpretations

<i>0 thru 10</i>	A person scoring in this range may not be able to tolerate alcohol.
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<i>16 thru 22(Women)</i>	This is the average range of scores for people in general.If people are substance abusers and score in this range,they may be secondary
<i>16 thru 23(Men)</i>	alcoholics,that is,theiralcoholism is secondary to their personal problems and it is used to avoid the pain they feel. Suicide pronealcoholics come from this group. Approximately 15%of diagnosed alcoholics are secondary alcoholics.
<i>23 thru 24(Women)</i>	If the person is self or other referred because of substance abuse problems, the Mae score confirms the diagnosis. If the person has psychological problems but
<i>24 thru 26(Men)</i>	substance abuse is not one of them, he/she may not be abusing alcohol <ol style="list-style-type: none"> 1. because of the "horrible" example of an alcoholic parent. 2. because of religious beliefs.
<i>25 or above (Women)</i>	For people without any psychological problems ofaddictions, this score may be a false positive (labelingpeople addictive when they are not). Scores in this
<i>27 or above (Men)</i>	rangeindicate addictive potential that may be acted upon (inalcoholics and drug abusers) or not (for those whorecognize the addictive potential but control it, perhapsthrough abstinence). The higher, the Mac scale and themore psychological pressure the person is under, thegreater the likelihood of substance abuse.

APS–Addiction Potential Scale

- Weed, Butcher, McKenna, & Ben-Porath (1992)
- 39 items that were endorsed differently by substance abusers compared with both nonclinical and psychiatric inpatient samples
- no item contains obvious reference to substance abuse
- see the MAC-R for T-scores

Addiction/Substance Abuse Scales: *Addiction Potential Scale*

(APS)

Items: 39; 23 keyed *True*

Major Internal Correlates: *Pd5, Ma2, ANX, ANG2, NEGE* and, negatively, *L, K, S, O-H, Re.*

Most Useful Comparisons: *AAS, MAC-R, A, R, DISC.*

Description/Interpretation: Developed by Weed, Butcher, McKenna, and Ben-Porath (1992) from comparing the item endorsement rates between substance abusers and separate reference groups of normals and psychiatric patients. Items are very heterogeneous in content and difficult to characterize concisely. Like *MAC-R*, *APS* is a subtle measure of substance abuse. *APS* may be more sensitive to substance abuse in patients whose profiles show relatively high levels of distress (e.g., *A*, Scales 2, 7, and/or 8, etc.). It may better discriminate substance abusers from psychiatric patients than *MAC-R*, but the strength and reliability of *APS* for this purpose needs further confirmation. Little information is currently available for clinical description based on *APS* scores. The pattern of aforementioned internal correlates suggests that the high scorer may be emotionally distressed, with oversensitivity, guilt, irritability, but also acting out and irresponsibility.

Addiction Potential Scale (APS)

After the revision of the original MMPI and expansion of the item pool, a broader range of substance abuse items became available in the instrument. Weed, Butcher, McKenna, & Ben-Porath (1992) were interested in developing an empirical scale that could improve upon earlier measures for the detection of substance abuse problems. The APS was developed as a measure of the personality factors underlying the development of addictive disorders. Items that differentiated alcohol and drug abusers were contrasted with psychiatric patients and nonclinical participants who were not substance abusers. For the development of the APS, larger samples of substance-abusing people, psychiatric patients, and normative population were tested in a cross-validated design than had been used in the original work on the MAC scale. The APS showed high reliability and predictive validity. This measure contains 39 items, only 9 of which overlap with the MAC-R scale. An elevated score on the APS is associated with the likely membership of the client in samples of substance-abusing patients. High elevations on APS suggest that the client shows a great potential for developing substance abuse problems. Low scores on APS are not interpreted because research has not been conducted on low-ranging scores at this time (see studies by Clements & Heintz, 2002; Rouse et al., 1999; Weed et al., 1992).

AAS–Addiction Acknowledgment Scale

- Weed, Butcher, McKenna, & Ben-Porath (1992)
- 13 items that were selected because of their obvious content relation to substance abuse supplemented by internal consistency procedures
- more face-valid than the APS
- see the MAC-R for T-scores

1. however, because the items for this scale were selected for their face validity, the absence of an elevation on this scale cannot be taken as a negative indicator of substance abuse

2. bottom line: elevations are indicative of some sort of substance abuse problem; lack of elevation does not mean there is no problem

Addiction/Substance Abuse Scales: *Addiction Admission Scale*

(AAS)

Items: 13; 10 keyed *True*

Major Internal Correlates: *Pd-5, Pd-O, ANGI, ASP2, FAM, DISC* and, negatively, *S, Re*.

Most Useful Comparisons: *MAC-R, AAS*.

Description/Interpretation: Developed by Weed, Butcher, McKenna, and Ben-Porath (1992) on internal consistency analyses of MMPI-2 items acknowledging substance abuse and related problems. This scale functions largely as a set of critical items for substance abuse problems, with high scorers acknowledging such problems and low scorers denying them.

Addiction Acknowledgment Scale (AAS)

The MAC-R and APS were developed as empirical measures to detect the presence of personality or lifestyle characteristics associated with alcohol or drug abuse problems. These measures do not address acknowledging substance abuse on the part of the client but indirectly address the problem by finding how the client resembles substance abusers in general personality makeup. In their research, Weed et al. (1992) took a somewhat different

approach in an effort to address a patient's willingness or unwillingness to acknowledge having substance abuse problems. The AAS was developed as a measure of substance abuse problem denial.

The AAS evaluates a client's willingness to acknowledge problems with alcohol or drugs and provides a psychometric comparison of the client's actual admission of alcohol or drug problems with other known groups. The 13-item AAS scale, with fairly obvious item content, was developed using a combined rational and statistical scale development approach. The items were initially chosen because they contained clear substance abuse problems. These items were then correlated with the remaining MMPI-2 item set to determine if additional items were associated with the initial substance abuse indicators. The provisional scale was refined further by examining the alpha coefficients, keeping only those items that increased scale homogeneity. The AAS has been shown to be an effective assessment indicator of substance abuse problems in psychotherapy clients (Clements & Heintz, 2002; Rouse et al., 1999). Given the obvious content structure, interpretation of the AAS is relatively straightforward. An elevated scale score, above a T score of 60, indicates that the client has acknowledged a large number of alcohol or drug use problems compared with people in general from the normative sample. The more items endorsed, the more problems the individual has acknowledged. A low score on the scale does not necessarily mean that the client does not have substance abuse problems, only that the person has not admitted to having problems or has denied problems. A particular client could have very significant substance abuse problems but choose to avoid acknowledging them. The profile of the case example shown in Figure 4.2 illustrates the use of the three substance abuse detection scales (MAC-R, APS, and AAS) together because they provide different types of information about a client. The APS and MAC-R scales measure the potential for developing addictive disorders and provide information regarding the individual's lifestyle. The AAS scale provides a clear assessment of whether the client is aware of and willing to acknowledge these problems in the evaluation. In the case shown in Figure 4.2, both the APS and MAC-R indicated likely problems with substance abuse; however, the client acknowledged relatively few problems with drugs or alcohol, suggesting denial of problems.

A—Anxiety Scale

- Welsh 1956
 1. based on a factor analytic study of the basic validity and clinical scales of the MMPI
 2. it is the first factor that comes out
- 39 items

T-Scores > 65 (marked elevation) are indicative of individuals who:

1. are anxious and uncomfortable
2. have a slow personal tempo
3. are pessimistic, apathetic, unemotional, unexcitable, shy, and retiring
4. lack confidence in themselves / their abilities
5. are hesitant and vacillating
6. are inhibited and overcontrolled
7. are influenced by diffuse personal feelings
8. are defensive
9. rationalize and blame others for their problems / difficulties
10. lack poise in social situations
11. are conforming and overly accepting of authority
12. are submissive, compliant and suggestible
13. are cautious and fussy
12. have a high commitment to feminine values
13. are seen as cool, distant, and uninvolved
14. are confused, disorganized and maladaptive under stress
15. are uncomfortable enough to be motivated to change in psychotherapy
16. are motivated in therapy once trust has been established

T-Scores 58-64 (moderate elevation) are indicative of individuals who:

T-Scores < 44 (low scores) are indicative of individuals who:

1. lack anxiety or uncomfortableness
2. are active, vigorous, expressive, colorful and verbally fluent
3. are frank and outspoken, friendly, and informal
4. who assume the ascendant role in relationships
5. are persuasive
6. are efficient, capable, clear thinking, versatile and resourceful
7. are self-confident
8. are competitive and value success and achievement
9. have an increased need for power, status, and recognition
10. manipulate others
11. have a decreased impulse control
12. have a low delay for gratification

Supplemental Scales: First Factor (Scale A [*Anxiety*])

Items: 39; 38 keyed *True*

Major Internal Correlates: Scales 7, 8, and 0, *D1*, *D5*, *Hy3*, *Pd5*, *Sc4*, *Si3*, *ANX*, *OBS*, *DEP*, *LSE*, *WRK*, *TRT*, *RCd*, *NEGE*, *Mt*, *PK*, *PS*, *GM* (low) and, negatively, *K*, *S*, and *Es*.

Most Useful Comparisons: See Major Internal Correlates, *DEP* and *RCd* in particular.

Description: Items reflect disturbed concentration and decision making; dysphoria, anxiety, and worry; fatigue, discouragement, and lack of initiative; inadequacy, inferiority, and sensitivity; and a sense of deviance and isolation. *A* is the traditional marker for the general maladjustment/subjective distress dimension in the MMPI-2 item pool. It is most useful as an index or point of reference against which to judge the elevations on the narrower distress scales (*ANX*, *DEP*, etc.), because the latter are highly intercorrelated and are likely to elevate as a group. For example, when *WRK* is higher than *ANX*, *OBS*, *DEP*, and *LSE*, and also exceeds the elevation on *A*, it becomes more likely that the elevation on *WRK* relates to specific employment-related concerns rather than to more general distress, discomfort, concerns about functioning, and so on. Likewise, when *ANX* exceeds *OBS*, *DEP*, *LSE*, and *WRK*, and also exceeds *A*, the elevation on *ANX* is more likely to reflect specific anxiety-related symptoms (e.g., tension, dread, panic, worry, distractibility, shortness of breath) than general distress, dysphoria, rumination, and so forth. Because *A* begins to top out as *T*-scores reach about 80, these relationships begin to break down at very high elevations. This scale is discussed more extensively in Friedman et al. (2001).

Interpretation: In general, high scorers may be described as uncomfortable, unhappy, and apprehensive. The anxiety they experience appears to be directed more toward a sense of their own incompetence than toward a sense of external threat. Their worry over the adequacy of their performances renders them hesitant, distractible, and vacillating, which makes them subject to others' influence. Under stress, they tend to become confused, disorganized, and maladaptive. They cope with their feelings of inadequacy by being cautious and standoffish, avoiding initiative and involvement, and inhibiting action. In interaction with others they tend to be timid, awkward, passive, and easily rattled. Provided that the pattern of validity indicators is not overly defensive, low scorers show confidence in their abilities, are comfortable, friendly, expressive, and assertive; they take initiative and are active, readily involved, vigorous, forceful, versatile, and achieving. In some cases, low scorers are better described as egocentric, ostentatious, overconfident, outspoken, competitive, overbearing, manipulative, reckless, and impulsive.

Factor Scales *A* and *R*

Welsh's purpose in developing the *A* and *R* scales was to provide a convenient means of locating respondents along the two primary dimensions that had been repeatedly identified in factor analyses of the basic clinical and validity scales of the MMPI. Although prior analyses had found varying numbers of factors, depending on the sample and the numbers of scales included in each, the primary dimension had consistently shown high positive loadings on

Scales 7 and 8 and high negative loadings on *K*. Thirty-nine items (38 keyed True, 1 keyed False) that achieved a 75 percent separation between the top and bottom 10 percent of the distribution of a preliminary scale (*G*; Meehl & Hathaway, 1946) of both of two groups of male VA patients were chosen for the scale that Welsh called *A* for Anxiety. *A* became, and remains, the most widely acknowledged marker for the first factor of the MMPI/MMPI-2.

The great response style debate that raged in the decade from 1955 to 1965 was largely concerned with whether the first factor of the MMPI should have a substantive (psychopathologic) or stylistic (test-taking attitude) interpretation. Although this controversy was never fully resolved, it cooled rapidly after Block (1965) demonstrated that even when the two main stylistic features of MMPI performance (social desirability and acquiescence) were controlled, the first and second factors of the MMPI continued to be associated with highly meaningful external correlates.

Among the clinical scales, the best marker for the first factor is Scale 7 (*Pt*). It is, therefore, instructive to compare *A* with *Pt*. *Pt* is about 20 percent longer than *A*; the two scales overlap by 13 items, or one third of *A*. Of these, the content of five items is depressive, three are anxious, two are obsessive, two suggest interpersonal aversion, and one admits problems in concentration. Examining the scale as a whole, *A* overlaps *DEP* by nine items (four from *DEP2*), *ANX* by seven, and *OBS* by five. *A* overlaps Scale 8 (*Sc*) by eight items, five of which are from subscale *Sc4* (Lack of Ego Mastery, Conative).

Thus, the content of *A* emphasizes disturbed concentration and decision making, as well as dysphoria, anxiety, and worry. Other content emphasizes fatigue, discouragement, and lack of initiative; inadequacy, inferiority, and sensitivity; and a sense of deviance and isolation. All of the items are obvious and socially undesirable. Despite its age and the particular circumstances of its development, *A* remains an excellent marker for the first factor. For example, it correlates at .98 with the 72 items of JBW72 (see Nichols, 2006), the set of items common to the first factor found in the replicated principal components analysis of the MMPI item pool (Johnson et al., 1984; *Ns* = 5,506 and 5,632), and replicated in turn by Waller (1999; *N* = 28,390), among the combined 25 samples reported by Rouse, Greene, Butcher, Nichols, and Williams (2008; *N* = 83,162).

The empirical correlates for high *A* scorers among the Graham et al. (1999) outpatients tend to confirm the description given above, but suggested relatively severe symptomatology, with many of these patients having histories of previous psychiatric hospitalizations. They presented with multiple symptoms of depression and anxiety,

and were seen as sad, depressed, insecure, hopeless, self-degrading, and with suicidal ideation. In their sample of normal adults, Hoffman and Pietrzak (2012) found Adjective Check List (ACL; Gough & Heilbrun, 1983) correlates that emphasized nervousness, anxiety, worrying, confusion, immaturity, and pessimism (all $> .35$).

Evaluation of the discriminative validity of scales developed for assessing distress syndromes must take the first factor into account, as this source of variance can readily create an appearance of validity in single-group comparisons. Provided that one group is more distressed than another, no matter what the exact phenomenological coloring of the distress in question (whether anxious, depressed, panicky, etc.), such scales will virtually always show evidence of convergent validity. That is, scales of this kind will evidence sensitivity to distress as such but will lack the specificity to discriminate one form of distress from another.

As the major marker for the first factor of the MMPI-2, *A* plays an important dynamic role in determining the pattern of test findings. Among the basic clinical and validity scales, elevations on *A* tend to suppress *K* (and therefore the raw amounts of *K* added as corrections for five of the eight basic clinical scales), increase positive profile slope, and increase the probability that Scales 7 and especially 8 will figure in the code pattern. *A* elevations also exert widespread pressure on the content scales to enter the range above *T*-65, with its heaviest influence on *NX*, *OBS*, *DEP*, *LSE*, *WRK*, and *TRT*. Among the supplementary scales, *A* tends to exert positive pressure on *Mt*, *PK*, *PS*, and *Ho*, and negative pressure on *GM*.

The major interpretive significance of high *A* scores is that the respondent readily admits distress and maladjustment. Duckworth and Anderson (1986) asserted that *A* reflects short-term, situational (state) anxiety, in contrast to *Pt*, which they believed represents long-term, characterological (or trait) anxiety. Although their distinction is intriguing and worthy of investigation, the higher test-retest stabilities of *A* items, relative to those of *Pt*, would argue against overconfident reliance on this hypothesis. On the other hand, as Duckworth and Anderson point out, the two scales show important differences in item content. The overlap between Scales 7 and 8 at 17 items is greater than that between Scale 7 and *A*, and more than twice that between Scale 8 and *A*. This alone would suggest a tilt toward a trait interpretation of Scale 7 relative to *A*. The content of Scale 7 carries a greater emphasis on ingrained, global personal defects, such as feeling useless, lacking self-confidence, and being incapable. It also implicates more severe cognitive disruption, including problems with memory and comprehension, and fears of losing mental control, over and above the problems with concentration and indecision noted for *A*. The content

on Scale 7 reflecting acute emotional instability and irrational fearfulness is entirely absent from *A*. Finally, the word *worry* (-ied, -ing) appears three times on *A* but only once on Scale 7, whereas *anxiety* (-ious) appears twice on Scale 7 but only once on *A*.

Regardless of the merits of assigning *A* and *Pt* state and trait implications, respectively, Caldwell (1988) cautioned that differences in their elevations may be confounded by the *K* correction for *Pt*. Thus, in comparing the scores on these two scales, it is recommended that *A* be compared only with the non-*K*-corrected version of *Pt*. However, because *A* has fewer items and is less positively skewed than Scale 7, it tops out about 10 *T*-score points lower than *Pt*. For example, the endorsement of two thirds of the items on both scales results in *T*-scores of about 78 on Scale 7 but only about 70 on *A*, with this difference increasing slightly as the proportion of the items endorsed on both scales increases. For this reason, especially when *K* is not too far below the average range, the interpretation of *A* may be undertaken confidently at somewhat lower levels of elevation than Scale 7, and protocols in which *A* exceeds Scale 7 (usually in association with elevations on Scale 0) may have particular significance.

In general, high *A* scorers may be described as uncomfortable, unhappy, and apprehensive. The anxiety they experience appears to be directed more toward a sense of their own incompetence than toward a sense of external threat. Their worry over the adequacy of their performances renders them hesitant, distractible, and vacillating, and this in turn makes them subject to the influence and suggestion of others. Under stress, they tend to become confused, disorganized, and maladaptive. They cope with their feelings of inadequacy by being cautious, standing off, maintaining their distance, avoiding initiative and involvement, and inhibiting action. In interaction with others, they tend to be timid, awkward, passive, and easily rattled.

Provided that the pattern of validity indicators is not overly defensive, low *A* scorers may be described as showing confidence in their abilities, comfortable and friendly, expressive and assertive, taking initiative, active and readily involved, vigorous and forceful, versatile and achieving. In some cases, low *A* scorers are better described as egocentric, ostentatious, overconfident, outspoken, competitive, overbearing, manipulative, reckless, and impulsive. The items for Welsh's *R* were selected by comparing the top and bottom 10 percent of the distribution of scores on Scale 2. Forty items that achieved separations of 60 percent or more in both VA patient groups comprise *R* (3 of these were dropped in the transition to MMPI-2; the remaining 37 are all keyed False). Despite marking the second major source of variation among the standard validity and clinical scales of the MMPI/MMPI-2, *R* achieves no better than moderate correlations with any of these scales. Its highest correlations are with Scales 2 and 9, at .30 to .40 and at -.40 to -.45, respectively. Correlations in the range of .30 to .40 are also seen for *L*, *K*, and Scale 0. Notable item overlap occurs with Scales 2 (10 items [*D-O*, six items; *D-S*, four items]) and 0 (eight items).

The content of *R* is fairly heterogeneous, including poor health and physical symptoms; inhibited if not blunted emotionality, particularly with respect to “negative” feelings and feelings of energy and excitement; a lack of enjoyment in and under-responsiveness to the potential stimulation of group membership and social interaction; the avoidance of conflict, competition, and social visibility; and a denial of activities and interest in pursuits that may occasion fatigue or stimulation. Taken as a whole, the content of *R* suggests the suppression of emotionality and the avoidance of interactions with the human and nonhuman environment that may stimulate feeling, whether positive or negative, with the tendency to refer such feeling, when it occurs, to events in the somatic sphere.

Although *R* scores have been available for more than 40 years, surprisingly little is known of the interpretive significance of high and low scores. Interpretations tend to converge on some notion of *control*. In his choice of Repression as the designation for *R*, Welsh (1956) evidently favored a construct believed to operate in an unconscious fashion. Welsh based his choice on the kinds of mental disorders associated with high and low scores on *R*: “The disorders exhibited by high *R* scorers are characterized by repression and denial; low *R* accompanies externalized and ‘acting-out’ behavior” (p. 280). More recent commentators have tended to reject the unconscious implications of Welsh’s construct in favor of a kind of emotional control that is seen to operate within awareness. Thus, Duckworth and Anderson (1986, p. 245) refer to *R* as “a conscious repression scale (or suppression scale to be more accurate)” that reflects a coping style emphasizing limited insight, (conscious) denial and rationalization, and decisions to limit self-disclosure. Similarly, Caldwell (1988) favored an interpretation of *R* as *constriction*, in which the person’s “range of feelings is limited and whose emotional responsiveness is constricted across a wide spectrum” (p. 76).

As noted by Nichols and Greene (1995), a comparison of the pattern of MMPI/MMPI-2 scale correlates with *R* and *EC-5* (Ego Control), Block’s (1965) second-factor scale suggests an alternative but related interpretation of *R*. Whereas the correlates of *EC-5* suggest the modulation and containment of impulse and aggression, a narrowing of interests, and a deliberate, conforming, prosocial, and risk-averse approach to decision making and behavioral expression, the correlates of *R* appear to reflect a more central locus of inhibition, one related to the strength of impulse and emotionality, and to openness to experience. Specifically, the high *R* scorer appears to be one who is uncomfortable with more than minimal levels of stimulation and emotionality, and who therefore prefers to operate in circumstances that are conventional, predictable, familiar, and overlearned. Such preferences, in turn, suggest limitations in the individual’s capacity to become aware of, identify, differentiate, and reflect on feelings and other emotional phenomena, and it is this that is the basis for the person’s constricted expression of emotionality. By

contrast, low *R* scores suggest a ready access to feeling and impulse even if not impulsively expressed; an openness to experiencing them; a prodigal and unstable pattern of interests; a high tolerance for stimulation; a willingness to entertain unfamiliar or unconventional points of view; and an ability to tolerate ambiguity, uncertainty, and conflict. Extremely low scores may be associated with chaotic emotionality, in which the individual feels flooded with emotionality or even euphoria, and is overinclusive and indiscriminate in his or her approach to expression.

Graham et al. (1999) reported only somatic symptoms and health preoccupation as broad empirical correlates of high *R* scores among their psychiatric outpatients. The normal adult ACL correlates found by Hoffman and Pietrzak (2012) included tough, show-off, flirtatious, hard-headed, daring, aggressive, loud, sly, and sociable (all $-.25$ to $-.35$).

(First Factor or Conscious Anxiety Scale)

The A scale seems to measure the amount of overt anxiety present when the test was taken. Scores on this scale frequently are elevated on profiles of clients seeking help for personal problems in college counseling centers and in mental health agencies. The higher the A score, the more anxiety the person is reporting. A low scale score ($T = 45$ or below) indicates relative freedom from conscious anxiety. The A scale correlates highly with measures of anxiety for medical out-patients, (.90 with scale 7, .85 with the Ca scale Appendix C) (Swenson et al., 1973).

An individual with a high A score is likely to have the following characteristics:

1. self-doubt,
2. difficulty in concentrating,
3. a tendency to worry and brood,
4. lack of energy,
5. a negative outlook on life generally.

The high A scale score with high Clinical scale scores is an indication that the person is hurting enough to be a good therapy risk, unless the situation that provoked the high A has changed dramatically since the test taking, thereby lessening the pressure on the client. Clients with low A scale scores (45 or below), but with many problems indicated on the Clinical scales, are usually poor therapy risks because they are not highly anxious about their problems and/or have learned to live with them even though these problems have not been solved.

People with high A scores and high Clinical scores may be good therapy risks. First, high A scorers tend to be very ready to admit to having psychological problems, and therefore, the Clinical scales may be elevated because of this

tendency and not because of having serious problems. Second, because high A scorers have much self-doubt, they may be more aware of a need to change their behavior and may be willing to work at doing so. Third, high A scorers may be cautious about showing unusual feeling and behavior. Such individuals do not want to be viewed as abnormal, and they may be in less trouble because of their cautious behavior.

In summation, a client who is highly anxious (high Scale A) and who generally feels maladjusted (high Clinical scales) is more likely to seek help and work on changing than a client whose answers on the test indicate pathology (high Clinicals) but who does not seem to be overtly anxious about his/her psychological adjustment (low A scale). Scale A seems to represent short-term, situational anxiety, whereas scale 7 (the other anxiety scale on the MMP1) seems to represent long-term characterological anxiety, a way of dealing with life by ruminating and worrying a great deal. This rumination and worrying may go on all or most of the time, even when a specific situation about which to worry is not present. High scale 7 people, in general then, tend to be chronic worriers, even when the worry is not immediately necessary.

Scale A usually shows anxiety in response to a particular situation and may be high when scale 7 is in the typical range (45 through 60). A person with this combination (high A scale, average 7 scale) is usually worrying about a specific problem but does not have the chronic worrying shown by a high scale 7. We have found that a typical reason for a person having this combination is because he/she is anxious about taking the test but is not an anxious person or worried about a large number of things.

In some cases, the 7 scale may be elevated without the A scale being above 60. In this instance, the person tends to be a chronic worrier, but at the time of taking the test he/she was not overtly worried about a specific situation.

An examination of the items that make up the A scale in comparison with those which make up the 7 scale is useful in pointing out some of the differences between the two scales. One group of items on both scales has to do with self-doubt. The 7 scale self-doubts seem to involve the total person more than those on the A scale. For example, "I certainly feel useless at times," is an item on scale 7. The self-doubt of the individual with a high A scale score is more in regard to interactions with people such as, "I feel unable to tell anyone all about myself."

A second group of items that sets the A scale apart from the 7 scale is those that have to do with phobias which are on the 7 scale but not on the A scale. A third set of items indicates that a high 7 scale individual is likely to have fits of excitement and anxiety; whereas, the high A scale individual is more likely to report the presence of steady anxiety.

Despite these differences, scales 7 and A have much overlap and usually are seen as elevated together rather than one elevated and the other not. When these two scales are elevated, the anxiety is both chronic and situational.

Scales A and R have a unique relationship to each other. In addition to looking at them separately, they also should be looked at together and interpreted in light of each other. In your work with the A scale as well as the individual A scale interpretations, we would suggest that you look at the A and R combinations, pp. 251-252.

GENERAL INFORMATION

- 1) The 39 items of the A scale reflect general, conscious emotional upset by asking questions concerning thinking and thought processes, negative emotional tone, lack of energy, pessimism, and personal sensitivity.
- 2) Welsh (1956) factor analyzed the MMPI items, and from this analysis he derived the A scale as a measure of one of the two main MMPI factors. (Scale R measures the other factor.) This first factor has high positive loadings on scales 7 (.90) and 8 (.79) and a high negative loading on scale K (-.71) (Swenson et al., 1973).
- 3) The A scale is strongly related to indices of overt anxiety and seems to measure tension, nervousness, and distress.
- 4) The A scale measures general conscious anxiety of a situational nature, as contrasted to scale 7, which measures a more characterological, long-term anxiety.
- 5) Welsh's A scale (1956) appears to be the most satisfactory single measure of conscious anxiety on the MMPI.
- 6) High and low scores can be "good" or "bad," appropriate or inappropriate, helpful or a hindrance, depending upon the specific situation of the person.

For example, if a person is facing a situational trauma and he/she is not very anxious about it (low to average A score), this lack of anxiety could be a hindrance to working through the trauma.

- 7) Heppner and Anderson (1985) have found that ineffective problem-solvers tend to be significantly higher on this scale than effective problem solvers.
- 8) In addition to interpreting the A scale alone, in certain instances the A scale should be considered in relationship to the R scale. See the A and R combination table
- 9) In one test-retest study, over a period of 11 days, the A scale was unstable (Jurjevich, 1966). This fact implies that the scale is quite mobile, hopefully in response to differing levels of anxiety.
- 10) Items of the A scale tend to be of uniformly low social desirability (Wiggins & Rumrill, 1959).
- 11) Under ideal-self instructions ("Take this test trying to look as good as possible") the one scale with the largest shift was the A scale; it became significantly lower (Parsons et al., 1968).
- 12) An excellent reference for the A scale is "Factor Dimensions A and R" by Welsh in Basic Readings on the MAIN in Psychology and Medicine (Welsh & Dahlstrom, 1956).

HIGH SCORES (T = 60 or Above)

See also the A and R combinations, pp. 251-252.

1. High A scores indicate that the person is overtly anxious. The higher the score, the more anxious the person is.
2. Men with high A scores have been described as lacking confidence in their own abilities and unable to make decisions without hesitation, vacillation, or delay (Block & Bailey, 1955).

- a. They tend to be suggestible and respond more to evaluations made of them by others than they do to their own self-evaluations. However, they may not act on others' evaluations but just worry about them.
- b. These men tend to lack social poise and are upset easily in social situations.
- c. They usually are pessimistic about their own professional future and advancement.

3. Gough (Welsh & Dahlstrom, 1956) reported people with high A scores have slow personal tempo and are pessimistic, hesitant, and inhibited.

LOW SCORES (T = 45 or Below)

See also the A and R combinations,

Clients with low scores tend not to be consciously anxious.

The non-anxiety may be "good" (when nothing exists about which to be anxious) or "bad" (when the Clinical scales indicate problems exist which should concern the person).

COMBINATIONS

A-R

- Nine combinations of A and R are discussed by Welsh (1965) and are found in the 1972 Dahlstrom, Welsh, and Dahlstrom MMPI Handbook. These interpretations have not been very accurate for our populations, except for the high A and high R interpretation, which follows:

High A (55 or above) and high R (55 or above): Depression often is encountered with accompanying tenseness and nervousness as well as complaints of anxiety, insomnia, and undue sensitivity. Generalized neurasthenic features of fatigue, chronic tiredness, or exhaustion may be seen. These subjects are perceived as rigid by others and are chronic worriers. They suffer from feelings of inadequacy and a brooding preoccupation with their personal difficulties (Welsh, 1965).

- For a summary of selected A and R scale combinations, see the chart on p.251-252.

SUMMARY OF A SCALE INTERPRETATIONS

<i>T-Score</i>	<i>Interpretations</i>
<i>45 or below</i>	<p>This person is not consciously anxious.</p> <p>The average score for well-functioning individuals is 45.</p>
<i>45 thru 60</i>	<p>This person has minimal (T = 45 to 50) to mild (T = 50 to 60) conscious anxiety.</p> <p>The majority of people score below 50 T-score points.</p>
<i>60 or above</i>	<p>This person has a high level of conscious anxiety, which may cause debilitation as the scale is elevated. The person may lack poise, be easily upset, pessimistic, and not trusting of himself/herself. Such a person tends to be influenced by others' evaluations of him/her, although he/she may not always act overtly on these evaluations.</p>

Where T-scores are listed in two categories (i.e., 45 or below and 45 through 60) and a score is obtained that is listed for two categories, use whichever interpretation seems to be most appropriate for the individual.

R-Repression Scale

- Welsh 1956

1. based on a factor analytic study of the basic validity and clinical scales of the MMPI
 2. it is the second factor that comes out
- 37 items

T-Scores > 58 (moderate and marked elevations) are indicative of individuals who:

1. are submissive, unexcitable, conventional, and formal
 2. are clear thinking
 3. are painstakingly careful
 4. lead a cautious lifestyle and strive to avoid unpleasantness
 5. are unwilling to discuss their behavior and any problems they may have
- d. Normal range: **T-Score 45-57**

T-Scores < 44 (low scores) are indicative of individuals who:

1. are outgoing, energetic, expressive, uninhibited, and informal
2. have an enthusiasm for living
3. tend to be emotional, excitable, aggressive, shrewd and dominant

Supplemental Scales: Second Factor

(Scale *R* [*Repression*])

Items: 37; 0 keyed *True*

Major Internal Correlates: Scales 2, 3, and 9 (low), *D2*, *D-S*, *Hy5*, *Ma2* (low), *Ma-S* (low), *Si2*, *ASP* (low), *TPA2* (low), *AGGR* (low), *DISC* (low), *INTR*, *Re*, *MAC-R* (low).

Most Useful Comparisons: See Major Internal Correlates.

Description: A broad dimension of emotional control and inhibition. The kind of inhibition measured by *R* relates to the strength of impulse and emotionality and to openness to experience. Items are heterogeneous in content, including poor health and physical symptoms; inhibited if not blunted emotionality, particularly with respect to negative feelings and feelings of energy and excitement; a lack of enjoyment in and underresponsiveness to the potential stimulation of group membership and social interaction; the avoidance of conflict, competition, and social visibility; and a denial of activities and interests in pursuits that may occasion fatigue or stimulation. Content suggests the suppression of emotionality and the avoidance of interactions with the human and nonhuman environment that may stimulate feeling, whether positive or negative. It also suggests a tendency to refer such feeling, when it occurs, to events in the somatic sphere. This scale is discussed more extensively in Friedman et al. (2001).

Interpretation: High scorers appear to be uncomfortable with more than minimal levels of stimulation and emotionality, and they prefer to operate in circumstances that are conventional, predictable, familiar, and overlearned. Such preferences, in turn, suggest limitations in the individual's capacity to become aware of, identify, differentiate, and reflect on feelings and other emotional phenomena, and form the basis for the person's constricted expression of emotionality, in some cases to the extent of alexithymia. Low scores suggest a ready access to feeling and impulse even if not impulsively expressed; an openness to experiencing them; a prodigal and unstable pattern of interests; a high tolerance for stimulation; a willingness to entertain unfamiliar or unconventional points of view; and an ability to endure ambiguity, uncertainty, and conflict. Extremely low scores may be associated with chaotic emotionality, in which individuals feel flooded with emotionality or are even euphoric and are overinclusive and indiscriminate in their approach to emotional expression.

(Second Factor or Conscious Repression Scale)

We feel the *R* scale is a conscious repression scale (or suppression scale to be more accurate). A person with a high score on this scale seems to be saying, "Some areas of my life are none of your business." Determining what areas are off limits is impossible until the client is asked. For example, in one recent situation, a client with a high *R*, but with another wise average profile, stated that he did not want to talk about his recent departure from the ministry of his church. He felt fairly comfortable about his decision, as was indicated by the MMPI profile in general, but was still not ready to talk with others about his change in vocation.

While the high *A* scale seems to have some relationship to seeking help at a university counseling center, the *R* scale does not. Clients coming for help with personal problems tend to score above 55 T-score points on the *A* scale

whereas they average around 50 for the R scale. Normal college students tend to score below 45 T-score points on the A scale whereas they average around 50 for the R scale (Anderson & Duckworth, 1969). Thus the R scale seems to average around 50 T-score points regardless of personal adjustment.

Another unusual feature of the R scale is that it does not correlate above .50 with any of the other scales on the MMPI. (See Appendix C.) This is in spite of the fact that it is supposed to be a scale that accounts for the second largest amount of variance in the MMPI [The A scale measures the largest amount (Welsh, 1956).]

The items in the scale are quite varied.

A high score on the R scale suggests that the person:

1. has health concerns,
2. denies feelings of anger,
3. is socially introverted,
4. denies being stimulated by people, and
5. is not aggressive and lacks social dominance.

As has been mentioned previously, the R scale is not frequently elevated in clients seeking help at a college counseling center. Some clinical impressions however based on a sample of 32 MMPI's from a college counseling center population are as follows:

- When the R scale is elevated 60 T-score points or higher and the A scale is 5 T-score points or more lower than the R scale, the client is likely to be seen as shy and guarded in his/her behavior or in his/her reactions to the interviewer. In some cases, these clients may even be resistive to being in therapy or to having a psychological evaluation. In spite of the client's resistance to this particular situation, a history of dependency is likely. Physical complaints are common and are of an unshakable nature. No comments are in the case notes of these people to indicate that they have any insight into their problems. People working with them find them quite unresponsive to psychological explanations for their problems.

- On the other hand, when the R scale is elevated above 60 T-score points and the A scale is at least 5 T-score points or more higher, a much more pathological picture of the client is represented. The person not only is shy and guarded, but also is typically complaining of being isolated, depressed, and having suicidal thoughts. In a disproportionate number of these cases, some attempt at suicide has been made, although some of these attempts will have been attention seeking. These people complain of difficulty in concentrating and have periods of confusion. Usually also a negative family history is present, but this could be the result of a phenomenon which Chance (1957) reported in her investigation of individuals who had pleasant memories as opposed to those who had unpleasant memories. Those individuals with pleasant memories had R scores higher than their A scores. Those with unpleasant memories had A scores higher than their R scores.
- When both the R and the A scales are above 60 T-score points and approximately equal to one another (within 5 T-score points), the person tends to be shy and guarded with feelings of isolation, depression, and some history of dependency upon others for support.

This analysis of college student profiles would suggest that the interpretation of an elevated R scale is highly dependent upon its relationship with the A scale. A summation of the relationship between these two scales is found on pp. 251-252.

The low R score indicates a lack of conscious repression and perhaps a willingness to be open and self-disclosing to others. The R scale, as a conscious repression scale, contrasts with the 3 scale, which we see as an unconscious repression scale. In general, when a person has an R scale score above 55, scale 3 also is elevated. One scale may be elevated however without the other one being so. In the previous example of the ex-minister's non-willingness to talk about his departure from his church, the R scale was elevated (above 60) whereas the 3 scale was not. He recognized the problem area (average level 3 scale) but did not want to talk about it (high R). We have seen many situations where the opposite also was true: the clients used unconscious repression and denial a great deal (scale 3 high), but they were not consciously saying some areas were off limits (R scale average or below). These people are willing to talk about their problems if they recognize them, which they may not (high 3).

Scale R also has points in common with the K and Cn scales. An elevated K scale indicates that the person feels everything is all right with his/her life. A person with this scale elevation may not be able to look at things that are not going well. An elevated Cn scale indicates that the person controls to whom his/her behavior is shown. Some profiles have all four of these points (K, 3, R, and Cn) above 65. When this pattern occurs, these people may be saying in many ways and on many scales that they tend to restrict themselves to talking about some subjects (R) that usually are positive (K and 3), and that they will not expose themselves or their behavior to all people (Cn). The overall impression is that of a highly constricted person.

GENERAL INFORMATION

- 1) The R scale consists of 40 items measuring health and physical symptoms; emotionality, violence, and activity; reactions to other people in social situations; social dominance, feelings of personal adequacy and personal appearance; and personal and vocational interests.
- 2) From his factor analyses of the IVIMPI, Welsh (1956) developed the R scale as a measure of the second factor in the MIVIMI. (The first factor is measured by scale A.)
- 3) This scale appears to measure the use of denial and rationalization as coping behaviors and a lack of effective self-insight.
- 4) The R scale measures conscious repression and denial, as contrasted with scale 3, which tends to measure unconscious denial.
- 5) High or low scores can be "good" or "bad," appropriate or inappropriate, helpful or a hindrance, depending upon the specific situation of the person.

For example, if a person has lost a loved one, a high R score may indicate a situation that is therapeutic for a while, thus helping the person to keep going in daily life without collapsing.

- 6) Scale R items are more heterogeneous and neutral in social desirability value as compared to scale A items, which are homogeneous and of low social desirability (Wiggins & Rumrill, 1959).
- 7) Because all the items on the R scale are keyed false, one study has proposed that the R scale seems to be a measure of acquiescence, with low R scores indicating more acquiescence than high R scores (Edwards & Abbott, 1969).
- 8) In addition to interpreting the R scale alone, the R scale should be considered in relationship to the A scale in certain instances shown in the A and R combination table, pp. 251-252.
- 9) An excellent reference for the R scale is "Factor Dimensions A and R" by Welsh in *Basic Readings on the MMPI in Psychology and Medicine* (Welsh & Dahlstrom, 1956).

HIGH SCORES (T= 60 or Above)

See also the A and R combinations, pp. 251-252.

1. Clients scoring high on R seem to be saying that some areas of their lives exist which they do not want to talk about with others.
2. Graham (1977) reported that high R scale scorers may be plodders and unimaginative people.
3. In one study, high R males were seen as people who readily made concessions and sidestepped trouble or disagreeable situations rather than face unpleasantness of any sort (Block & Bailey, 1955).
 - a. They appeared highly civilized, formal, and conventional.
 - b. They seemed clear-thinking, but they were rated slow, painstaking, and thorough.

LOW SCORES (T = 45 or Below)

See also the A and R combinations, pp. 251-252.

1. People with low R scores are not trying to repress consciously any topics covered on the MMPI.
2. They probably are willing to discuss with someone problem areas covered by the MMPI insofar as they recognize these problems.
3. Their willingness to discuss these areas with a counselor may depend upon whether they see the counselor as one in whom they can confide and whether they feel the subject matter is appropriate to their counseling goals.

COMBINATIONS

A-R

1. For a summary of selected A and R scale combinations, see the summary on pp. 251-252.

SUMMARY OF R SCALE INTERPRETATIONS

<i>T score</i>	<i>Description</i>
<i>45 or below</i>	A person with a score in this range is not consciously repressing feelings or attitudes. The person is usually willing to discuss recognized problems that are perceived as relating to his/her counseling goals

<i>45 thru 60</i>	This person has minimal (T = 45 to 50) to mild (T = 50 to 60) conscious repression of feelings. The person may feel reluctant to discuss some topics with the counselor.
<i>60 or above</i>	A person with a score in this range has a strong need to consciously repress feelings. The higher the T-score, the greater the need to repress. This person usually prefers to avoid unpleasant topics and situations. He/she maybe seen as formal, logical, and cautious.

SUMMARY OF A AND R COMBINATION INTERPRETATIONS

<i>If A scale:</i>	<i>If R scale:</i>	<i>Interpretation</i>
<i>45 or below</i>	45 or below	<p>This person is neither consciously anxious or consciously repressing feelings. Three types of persons are in this category:</p> <ul style="list-style-type: none"> ○ Persons taking the MMPI as part of an experiment or class assignment ○ Persons seeking counseling for vocational guidance <p>Clients who are unconcerned about their behavior, such as alcoholics, hoboos, sociopathic persons, and so forth. These people may have a poor prognosis for change in therapy</p>
<i>60 or above</i>	45 or below	This person appears to be both anxious and open. This above below score combination usually is helpful for the counseling situation; the anxiety serves as motivation to work on problems, and the openness allows flexibility in both depth and breadth of subject areas. This combination is

		more common for people voluntarily seeking counseling for problems.
<i>45 or below</i>	60 or above	<p>This person is not consciously anxious, but he/she is consciously repressing information. This person is difficult to work with in therapy, because he/she is limiting the areas of discussion and is not sufficiently anxious to work on his/her problems. This combination is common for two groups of people:</p> <ul style="list-style-type: none"> • Persons seeking vocational counseling. The person feels that exploring certain areas of his/her life is not relevant to the task. • Job applicants who hold back certain data from the prospective employer and who wish to present themselves in a good light.
<i>60 or above</i>	60 or above	<p>This person is both consciously anxious and consciously repressing talking about areas on the test; however, if the R scale is higher than the A scale, the person could be denying he/she is anxious.</p> <p>This combination frequently occurs with an elevated 3 scale. This person is very difficult to work with in therapy. The prognosis for successful therapy is indicated by the relative heights of the two scales.</p> <p>If the A scale is 5 or more T-score points higher than R, the person may overcome his/her repressive tendencies because of the greater anxiety. If the R scale is 5 or more T-score points higher than A, the person might terminate counseling rather than look at his/her problems realistically.</p> <p>For an additional interpretation of this combination, see Welsh's (1965) interpretation on p. 243.</p>

O-H--Overcontrolled Hostility

- a. Megaree, Cook, Mendelsohn, 1967
- b. contrasted answers made by violently assaultive prisoners with answers made by nonviolent prisoners
- c. provides a measure of an individual's capacity to tolerate frustrations without retaliating

T-Scores > 65 are indicative of individuals who:

- 1. report fewer angry feelings and decreased verbal hostility
- 2. are more socialized and responsible
- 3. respond to provocation appropriately most of the time
- 4. occasionally display exaggerated aggressive responses

T-Scores < 40

- 1. not much data
- 2. may indicate chronic aggressive or individuals who are quite appropriate in the expression of their aggression

Supplemental Scales: *Overcontrolled-Hostility (O-H)*

Items: 28; 7 keyed *True*

Major Internal Correlates: Scales *L*, *K*, *S*, *Hy-S*, *Re* and, negatively, *Ma2*, *Si3*, *OBS*, *ANG2*, *TPA1*, *TPA2*, *NEGE*.

Most Useful Comparisons: See Major Internal Correlates.

Description/Interpretation: Developed by Megargee, Cook, and Mendelsohn (1967) to identify prisoners characterized by high levels of hostile impulse existing side-by-side with massive, rigid, and unconscious inhibitions against hostile expression. For these individuals, assaultiveness was seen as an atypical response that would occur only rarely and

unexpectedly, when the individual's normally hypertrophic defenses against the expression of hostility could be overcome. Whereas the undercontrolled individual's hostile reaction was typically proportional to its instigation, the overcontrolled individual's reaction was often seen as poorly calibrated to the instigating events, thereby increasing the importance of being able to identify the overcontrolled-hostile individual. The item content of the *O-H* scale is quite heterogeneous, with few identifiable themes. High scorers portray themselves as free of tension and internal conflict, although not of occasional worries and fears; as emotionally self-contained and impassive, if not underexpressive, imperturbable, and avoidant of stimulation and emotional or physical exertion. They deny impatience, irritability, and anger, and they portray themselves as relaxed and tolerant of boredom and frustrations; as noncompetitive and avoidant of willfulness and interpersonal conflict; but as nonetheless socially comfortable and able to seek advice from others.

Given its origins, a major application of *O-H* is in classifying male prisoners convicted of violent offenses. Because of the low base rates for violence in most other populations, it is unsuitable as a basis for predictions of assault, violence, or dangerousness. However, *O-H* scores may be used to infer the presence or absence of a pattern of personality dynamics consisting of both hostile alienation and excessive inhibitions around the expression of aggressive or hostile impulses—both of which reside largely, if not entirely, outside of awareness. This pattern would appear to predict a vulnerability to accumulating resentments over time and to a potential for releasing them in an explosive manner when provocations are great or when controls are diminished (e.g., due to intoxication). Quinsey, Maguire, and Varney (1983) found that their overcontrolled murderers lacked assertiveness and suggested that assertiveness training might alter the overcontrolled-hostile pattern.

Fixed cutting scores have not been developed for *O-H*, and Megargee et al. (1967) recommended that cutoffs be established on the basis of local norms and the utilities attaching to false-positive versus false-negative decisions. For purposes of orientation, however, among white men, raw scores of 15 or greater should raise the question of overcontrolled personality dynamics, with scores of 18 clearly indicating such dynamics, particularly when test indicators of self-favorable responding, *False* percentage, or both are no more than moderately elevated. Scores of 21 and higher appear to be associated with strong external evidence of these dynamics, regardless of response style. There is some evidence that African-Americans and women score somewhat higher on *O-H*, suggesting the need to adjust these scores upward before inferring overcontrolled dynamics among members of these groups (Graham, 1977). Because *O-H* reflects a syndrome (hostility/resentment + impulse overcontrol + lack of awareness of these), low scores are largely without interpretive significance. That is, a low score might signify the absence of any or all of these elements. Thus, person A might be inhibited and overcontrolled but neither hostile nor resentful, whereas person B might be hostile and resentful but neither inhibited nor overcontrolled. This scale is discussed more extensively in Friedman et al. (2001).

The stimulus for the development of the Overcontrolled-Hostility scale (Megargee et al., 1967) was the failure of 12 previously identified MMPI scales to achieve satisfactory identifications among a sample of male criminals who had been subdivided into extremely assaultive, moderately assaultive, and non-assaultive groups (Megargee and Mendelsohn, 1962). Moreover, there was a clear trend for the extremely assaultive criminals to score *lower* on these

measures than the other two groups, suggesting that the controls (or levels of hostility) in the extremely assaultive group were, if anything, better than in the comparison groups. Megargee reasoned that the group of extremely assaultive criminals might contain a subgroup of individuals that, far from fitting the stereotype of the habitually aggressive and impulsive person who manifests a low threshold for responding with hostility to frustrating events and provocations, characteristically do *not* react to such instigations. He posited that extremely assaultive individuals could be divided into under-controlled and overcontrolled types, with the overcontrolled group characterized by high levels of hostile impulse existing side by side with massive, rigid, and unconscious inhibitions against hostile expression. For these individuals, assaultiveness was an atypical response that would occur only rarely and unexpectedly, in circumstances of sufficient moment that the individual's normally hypertrophic defenses against the expression of hostility could be overcome. Whereas in the under-controlled individual the hostile reaction was typically seen to be in some sense proportional to its instigation, the overcontrolled hostile reaction was often seen as poorly calibrated to instigating events, thereby increasing the importance of being able to identify the overcontrolled hostile individual.

The *O-H* scale was derived to identify this overcontrolled hostile reaction type. Megargee et al. (1967) compared the responses of extremely assaultive ($n = 14$), moderately assaultive ($n = 25$), and non-assaultive ($n = 25$) male prisoners and a group of noncriminal men ($n = 46$). Item analysis yielded 55 items that separated the assaultive from the non-assaultive participants. These were then cross-validated on new samples of extremely assaultive, moderately assaultive, and non-assaultive prisoners. On the basis of the examination of prison records, Megargee et al. also compared the responses of prisoners who had histories of violence and were identified as conforming to the overcontrolled pattern with inmates with an under-controlled pattern of violence. Thirty-one of the 55 items survived cross-validation to become *O-H*. In the transition to the MMPI-2, *O-H* lost three items. Of the remaining 28, 21 are keyed False, 7 True. This T/F imbalance was suggested by Deiker (1974) to potentially account for the *O-H* score differences found between his most versus least violent criminals, that simple naysaying, i.e. the preference for responding False, could more parsimoniously account for the variance in *O-H*. In response, Megargee and Cook (1975) constructed four T/F balanced variants of *O-H*, and compared their performance in his derivation samples (Megargee et al., 1967). One of these actually improved upon the performance of *O-H*, indicating that the latter's T/F balance effect is likely negligible. Like most scales constructed using the method of contrasted groups, the item content of *O-H* is quite heterogeneous, with few if any identifiable themes. An examination of the structure of the MMPI version of *O-H* among 200 state penitentiary inmates found five factors (Walters & Greene, 1983), but subsequent analyses of other samples by R. L. Greene and D. S. Nichols (personal communication, March 1, 1999) cast doubt on the stability and coherence of the earlier solution. *O-H* shares three items each with the *L*, *K*, and *Es*

(scored in reverse) scales and four with *S* and *Hy*. It overlaps minimally with the MMPI-2 content scales; two items (scored in reverse) are shared with *ANG* and *WRK*. Among psychiatric patients, *O-H* is most highly correlated with scores on *S* and *K* (both $\sim .55$), and *ANG* and *TPA* (both $\sim -.55$). As Greene (2011) pointed out, it is unusual for a scale to share so few items with other scales, suggesting that *O-H* may be tapping a unique source of variance. On the basis of an examination of item content, the high *O-H* scorer portrays him- or herself as (a) free of tension and internal conflict, although not of occasional worries and fears; (b) emotionally self-contained and impassive, if not under-expressive and imperturbable, and avoidant of stimulation and emotional or physical exertion (they deny impatience, irritability, and anger, portray themselves as relaxed, and are tolerant of boredom and frustrations); and (c) noncompetitive, as well as avoidant of willfulness and interpersonal conflict (but nonetheless socially interested and comfortable), and able to seek advice and assistance from others. Gearing (1979), following Davis (1971), Davis and Sines (1971), and Persons and Marks (1971), noted the similarity of the personality descriptions for the *O-H* syndrome and the 4/3 MMPI codetype, and this suggestion was followed up in investigations by Walters, Greene, and Solomon (1982), and Walters, Solomon, and Greene (1982), who were able to confirm that despite important differences, the two indicators appeared to reflect the general similarity of their associated personality patterns.

The research on *O-H* has generally been supportive of its construct validity among male forensic psychiatric patients when administered within the context of the full MMPI (Lane & Kling, 1979; Quinsey, Maguire, & Varney, 1983; Schmalz, Fehr, & Dalby, 1989; and White & Heilbrun, 1995). Quinsey, et al. (1983), in particular, and consistent with Megargee's view, found both significant mean differences and substantial effect sizes for *O-H* between groups of murderers classified as overcontrolled versus under-controlled. Findings among youthful offenders are mixed, with both positive (White, 1975; and White, McAdoo, & Megargee, 1973) and negative (Truscott, 1990) results reported. The findings from various other investigations include higher *O-H* scores among driving-while-intoxicated offenders (Caviaola, Strohmets, Wolf, & Lavender, 2003), child custody litigants (Bathurst, Gottfried, & Gottfried, 1997), hospitalized sex offending Roman Catholic priests (Plante, Manuel, & Bryant, 1996), and Black than White forensic psychiatric inpatients (Hutton, Miner, Blades, & Langfeldt, 1992). Research on the validity of *O-H* among women is disappointingly meager, although a preliminary investigation (Jensen, 2004) found support for extending Megargee's overcontrolled typology to women. Investigations into the performance of *O-H* within non-forensic psychiatric populations are similarly much needed, and the findings thus far are not encouraging (Werner, Becker, & Yesavage, 1983). Although the research tends to support Megargee's distinction between persons prone to overcontrolled versus under-controlled patterns of violence, it is much less clearly related to the propensity for

violence as such, including murder. Group differences between violent and nonviolent groups have characteristically been small, compromising the predictive validity of *O-H* as applied to the individual case when the purpose of the assessment bears on the issue of dangerousness.

Given its origins, a major application of *O-H* is in the classification of male prisoners convicted of violent offenses. That is, the value of *O-H* primarily belongs in the postdictive context, providing a means for construing and classifying offenders following incidents of extreme assault. Because of the low base rates for violence in most other populations, it is unsuitable as a basis for predictions of assault, violence, or dangerousness. Data associating high *O-H* scores with violence in other than correctional populations are meager. Nevertheless, *O-H* scores may be suitable for inferring the presence or absence of a pattern of personality dynamics consisting of both hostile alienation and excessive inhibitions around the expression of aggressive or hostile impulses, both of which reside largely if not entirely outside of awareness. Quinsey et al. (1983) reported that their overcontrolled murderers lacked assertiveness and suggested that assertiveness training might be indicated as a means of altering the overcontrolled hostile pattern. This pattern would appear to predict a vulnerability to accumulating resentments over time and to a potential for releasing them in an explosive manner when provocations are great or when controls are diminished (e.g. because of intoxication). Fixed cutting scores have not been developed for *O-H*, and Megargee et al. (1967) recommended that cuts be established by setting on the basis of local norms and the utilities attaching to false-positive versus false-negative decisions. For purposes of orientation, however, among White men, raw scores of 15 or greater should raise the question of overcontrolled personality dynamics, with scores of 18 clearly indicating such dynamics, particularly when test indicators of self-favorable responding and/or False percentage are no more than moderately elevated. Scores of 21 and above appear to be associated with strong external evidence of these dynamics, regardless of response style. African Americans and women may score somewhat higher on *O-H*, suggesting the need to adjust these scores upward before inferring overcontrolled dynamics among members of these groups. Because *O-H* reflects a syndrome (hostility/resentment + impulse overcontrol + lack of awareness of these), low scores are largely without interpretive significance. That is, a low score might signify the absence of any or all of these elements. Thus, person A might be inhibited and overcontrolled but neither hostile nor resentful, whereas person B might be hostile and resentful but neither inhibited nor overcontrolled.

Do-Dominance Scale

- Gough, McClosky, & Meehl, 1951
- 30 items

- assesses an individual's tendency to be ascendant and controlling in interpersonal relationships
- constructed by contrasting groups of high school or college aged individuals who were nominated by peers as being high or low in dominance of social relationships

T-Scores Description

> 65	1. are poised, self-assured and take social initiative
	2. are persevering, resolute, and display leadership skills
	3. are confident in their ability to cope with environmental demands
< 40	1. are submissive, unassertive, and easily influenced by others
	2. are lacking in self-confidence and feel inadequate in handling their problems
	3. have difficulties being assertive
	4. criminals tend to have low Do scores

Supplemental Scales: *Dominance (Do)*

Items: 25; 6 keyed *True*

Major Internal Correlates: Negatively with scales *A*, *7*, *8*, and *0*, *D1*, *D-O*, *Pd5*, *Pd-O*, *Sc3*, *Sc4*, *Si3*, *OBS*, *DEP1*, *DEP3*, *LSE*, *WRK*, *TRT1*, *NEGE*, *Mt*, *PK*, *PS* and, positively, with *Es*.

Most Useful Comparisons: The *Do* construct appears to overlap significantly with that of *Es*, even though these scales share only four items.

Description/Interpretation: Developed by Gough, McClosky, and Meehl (1951) to identify positive social dominance (not domineering or autocratic behavior). Items are heterogeneous but reflect self-confidence, independence, relaxation, candor, and feelings of personal security; freedom from distractibility, indecision, worry, guilt, or preoccupations; sociability, good social skills, and social judgment; and constructive social attitudes, steadiness, and a capacity for self-restraint. High scorers demonstrate comfort, poise, initiative, and influence in social relationships. They appear secure, self-confident, self-assured, efficient, resourceful, and persevering. Their ability to elicit the confidence and social

approval of others may enable them to ascend to positions of responsibility and leadership within the group (e.g., being elected foreman on juries). This description and interpretation appear to converge on *Do*, at least as measured in the MMPI/MMPI-2, as an indicator of self-direction. As a construct, self-direction encompasses aspects of internal locus of control and independence of judgment, but without the implications of self-sufficiency or social distancing that these concepts sometimes carry. This scale is discussed more extensively in Friedman et al. (2001).

Dominance Scale (*Do*)

The Dominance scale (Gough et al., 1951) grew out of a larger project investigating political participation. The 25 items of *Do* on the MMPI-2, 6 keyed True, 19 False, form a subset of the 60-item Dominance scale (*Do*) of the California Psychological Inventory (CPI). The developers gathered peer nominations from high school and college students, with each student nominating the five most and five least dominant of their peers. The item responses of high and low dominance were compared. Care was taken to avoid confusing the construct of interest, dominance, with being domineering or autocratic and to ensure that peer ratings were based on nominees' actual behavior as opposed to how the peer thought the nominee might act, view him- or herself, and so on. Just how successful these efforts were in steering the nominations in the direction desired by the investigators is uncertain. Although the CPI version of *Do* is one of its better validated scales (Megargee, 1972), the MMPI/MMPI-2 version has stimulated surprisingly little research, although such research has been generally supportive. Greene (2011) reports a positive correlation for *Do* with *Es* (.66), and negative correlations in a range of .65–.75 for *Pt* (highest), *A*, *WRK*, *PK*, *Mt*, *Sc*, *TRT*, *LSE*, *DEP*, and *Si*, indicating relatively high saturation with the first factor; the pattern of overlap with other MMPI/MMPI-2 scales tends to reflect extraversion and the absence of anxiety. The textual literature of the MMPI/MMPI-2 (e.g. Butcher & Williams, 1992; Friedman, Webb, & Lewak, 1989; Graham, 1990; Greene, 2011) provides little insight into the core construct of *Do*, but describes high scorers as showing comfort, poise, initiative, and influence in social relationships; being secure, self-confident, self-assured, efficient, resourceful, persevering, and able to concentrate; and dutiful and having strong political opinions. Duckworth and Anderson (1986) described the high *Do* scorer as asserting that “he/she is able to take charge of his/her own life” (p. 273), an interpretation endorsed by Caldwell (1988) and Greene (2011). Both the descriptions and the interpretation just given appear to converge on *Do*, at least as measured in the MMPI/MMPI-2, as an indicator of *self-direction*. As a construct, self-direction would appear to encompass aspects of internal locus of control and independence of judgment, but without the implications of self-sufficiency or social distancing that these concepts sometimes carry. The high *Do* scorer tends to elicit the confidence and social approval of others that may move them in the direction of elevating the high scorer to positions of responsibility and leadership within the group. The outpatients with scores below

T-40 studied by Graham et al. (1999) often had histories of physical abuse (for women, also sexual abuse), and a broad range of symptoms, including depression, anxiety, somatization, and social awkwardness. The ACL correlates for the high *Do* scoring normal adults studied by Hoffman and Pietrzak (2012) tend to characterize them as calm, relaxed, and comfortable, clear-headed, self-confident, ambitious, cheerful, at ease, mature, sociable, optimistic, prudent, attentive, spirited, and fearless.

The *Do* scale is a fairly simple measure of a person's ability to take charge of his/her own life. The higher this scale, the more the person is saying that he/she is able to take charge of his/her own life. The *Do* scale may show domineering behavior when the scale is very high (above 70) and the 4 scale is above 70 T-score points. Even then, the person may not always show domineering behavior. The presence of the behavior seems to depend upon certain other scales being elevated with the *Do*, if the 5 scale is elevated 5 or more T-score points above the 4 scale for men or is below 40 T-score points for women, it may temper the domineering behavior.

The lower the *De* scale, the more the person is saying he/she does not want to take charge of his/her life. The lower *Do* score usually is accompanied by an elevation on the *Dy* scale. When this happens, the person usually wants other people to take over his/her life and wants to be dependent upon them.

In addition to interpreting this scale alone, its relationship with the *Dy* scale should be considered. We have found an elevation on the *Do* scale (when *Dy* is below 50) to be a good sign of progress in therapy. Also, elevations above a T-score of 60 on *Es*, *Do*, and *St* usually are signs of a healthy profile. The *Dy-Do* relationships are summarized on p. 277.

GENERAL INFORMATION

1. The *Do* scale of 60 items was developed by Gough, McClosky and Meehl (1951) and measures poise, self-assurance, resourcefulness, efficiency, and perseverance.
2. The scale was developed by the "peer group nomination technique." One hundred college and 124 high school students were asked to nominate the members of their group whom they considered to be the most and least dominant. Those items on the MMPI that differentiated between the two groups were used for the *Do* scale.

3. This scale seems to measure a person's ability to take charge of his/her own life.
4. The Do scale has been shown to be successful in predicting staff ratings and peer nominations for dominance and in identifying outstanding leaders in high school programs (Dahlstrom & Welsh, 1960).
5. In one study (Birtchnell & Kennard, 1983) no significant relationship was found between elevation on Oo and age or sex.
6. Heppner and Anderson (1981, 1985) have found that ineffective problem solvers tend to be significantly lower on this scale than effective problem solvers.
7. College students tend to score high on this scale with a mean of 60 T-score points (Anderson & Duckworth, 1969).
8. A group of college achievers scored higher than non-achievers on this scale (Morgan, 1952).
9. An elevated score on the Do scale has been found to be significantly related to middle management success (Miles, 1968).
10. In addition to interpreting this scale alone, in certain instances shown in the Dy and Do combination summary and discussed in the opening paragraphs of Dy scale, the Do scale is to be considered in relationship to the Dy scale.
11. The article originally proposing this scale is in the Basic Readings of the MMPI in Psychology and Medicine (Welsh & Dahlstrom, 1956).

HIGH SCORES (T = 60 or Above)

See also the Dy and Do combinations, pp. 277-278. 1. High scorers tend to be people who take charge of their lives. 2. When the person has a Do score above T of 75, he/she may be seen as a leader and/or domineering.

LOW SCORES (T = 50 or Below)

See also the Dy and Do combinations, pp. 277-278.

A person with a low Do score usually would like others to take charge of his/her life.

COMBINATIONS

Es-Do-St (T = 55 or Above) See Es.

Es-Do-31 (T= 45 or Below) see p. Es.

Dy-Do

For a summary of selected Dy-Do scale combinations, see pp.277-278.

T-Score Interpretations

<i>50 or below</i>	<p>A person with a score in this range prefers to have others take charge of his/her life at this time.</p> <p>This level is typical for clients in therapy.</p>
<i>50 thru 60</i>	<p>A person with a score at this level is able to control much of his/her life and at the same time is able to be dependent upon others periodically.</p> <p>This range is typical for people who do not have a college education.</p>
<i>60 or above</i>	<p>This person tends to take charge of his/her own life. He/she is able to meet deadlines, plan, and organize his/her life. At higher levels (T = 70 or above), a person may be seen by others as imposing or domineering if his/her 4 scale score is also above 70 T-score points.</p> <p>The mean for college students is a T-score of 60,</p> <p>See Dy-Do combinations, pp. 277-278.</p>

Re-Social Responsibility Scale

- Gough, McClosky, Meehl, 1952
- 30 items which assess concern for social and moral issues

T-Scores > 65 are indicative of individuals who:

1. have a deep concern over ethical and moral problems
2. have a strong sense of justice
3. set high standards for themselves
4. reject privilege and favor
5. place excessive emphasis on carrying their share of duty
6. have trust and confidence in the world in general
7. high scores on this scale indicate that the individual is less likely to be involved in criminal activity

T-Scores < 40 are indicative of individuals who:

1. are unwilling to accept responsibility for their behaviors
2. have low integrity
3. are less rigid and more carefree
4. are spontaneous
5. deny social value systems in favor of idiosyncratic values
6. are in the process of changing their value system or religion
7. criminals also have low Re scores

- scale constructed on 50 college males and 50 college females in the Greek system, 123 social science students, and 221 9th grade students who were divided into responsible and irresponsible groups

Supplemental Scales: *Social Responsibility (Re)*

Items: 30; 6 keyed *True*

Major Internal Correlates: Negatively with Scale 4, *Pd-O*, *Ma-O*, *Si3*, *ANG*, *CYN*, *ASP1*, *ASP2*, *TPA*, *FAM*, *MAC-R*, *AAS* and, positively, with *K*, *S*, *Hy-S*.

Most Useful Comparisons: It is noteworthy that the correlations of *Do* and *Re* with *K* are virtually identical, at .61 and .63, respectively, but their correlations with *Es*, at .68 and .38, respectively, are divergent.

Description/Interpretation: Developed by Gough, McClosky, and Meehl (1952) to identify “a ready willingness to accept the consequences of [one’s] own behavior, dependability, trustworthiness, and a sense of obligation to the group” (p. 74). Items reflect conformity to rules and expectations; model comportment in school; low stimulation-seeking and irritability; denial of selfconsciousness, anger, resentment, or cynicism; the avoidance of conflict; and selfcontainment. High scorers are seen as conventional and conforming but tolerant and even-tempered. They have benign expectations of others, exhibit self-control, are team players, and are able and willing to pledge allegiance to the collectives of which they choose to be a part.

Re measures a form of responsibility most likely to be manifested in institutional settings where creative demands are low. The institution may be as small as a family or club, or as large as a multinational corporation. The high *Re* scorer is one whose performance and achievement are best manifested in structured settings that place a premium on persistence, cooperation with others, and a duty-bound variety of conscientiousness. The core construct appears to be one of *dutifulness*. Thus, the responsible person is one on whom others can rely to observe and support the customs, norms, policies, and procedures of the institution and to advance its goals.

The *Re* scale is widely used in employment screening (Butcher & Williams, 1992).

Although low scores can be readily interpreted in terms opposite the aforementioned qualities, guidelines for interpreting *Re* scores greater than 50T need further exploration and research. It appears likely, however, that as scores of about 60T are exceeded, the dispositions of high *Re* scorers may be less adaptive than those closer to the average range. Duckworth and Anderson (1986) speculate

that higher-ranging scores may be associated with a lack of imagination and an excessive orientation to “oughts and shoulds,” giving rise to attitudes that the examinee’s associates may find annoying. Similarly, scorers in this range may be overly quick to identify with authority, regardless of its moral/ethical standing, and to sacrifice the interests of others, both within and outside of the organization, in the pursuit of narrow organizational goals. For example, one would expect the company man to have a considerably higher *Re* score than the whistle blower, even though both might be seen as socially responsible. This scale is discussed more extensively in Friedman et al. (2001).

Responsibility Scale (Re)

In many pretreatment evaluations it is desirable to assess whether the person entering therapy assumes responsibility for himself or herself and whether he or she approaches social relationships in a responsible manner. People tend to respond to treatment and are more willing to alter their negative behaviors if they care about themselves and others. One possible measure that reflects whether a person possesses social responsibility is the *Re* scale developed by Gough, McClosky, and Meehl (1952). They developed the *Re* scale empirically by employing groups of people who had been rated (by peers or by teachers) as “most” or “least” responsible in their group. Responsible individuals were viewed as those who were willing to accept the consequences of their own behavior, were viewed as dependable and trustworthy, were thought to have high integrity, and were believed to possess a sense of obligation to others. Four groups of subjects were employed in the study (50 college men and 50 college women, 123 social science students from a high school, and 221 ninth-graders). The MMPI items that became the *Re* scale were those that empirically discriminated the most responsible from the least responsible people. The item content centered on espousing conventional behavior versus rebelliousness, social consciousness, emphasis upon duty and self-discipline, concern over moral issues, possession of personal security and poise, and disapproval of favoritism and privilege. The MMPI Restandardization Committee, in the final item selection for MMPI-2, eliminated two items from the *Re* scale as objectionable, bringing the total number of items on *Re* in the MMPI-2 to 32. The reduction in items did not result in a reduction in scale reliability: the test–retest correlations for *Re* reported for the MMPI-2 (Butcher et al., 1989) was 0.85 for males and 0.74 for females. This is consistent with the test–retest reliabilities (0.85 for males and 0.76 for females) reported by Moreland (1985) for the original MMPI.

Individuals who score high on Re, a T score above 65, are viewed as having a great deal of self-confidence and a generally optimistic, positive view toward the world. They are considered by others as conventional and conforming. They are seen as having a strong sense of justice and a deep concern over ethical and moral problems. They are thought to have a strong sense of fairness and justice, tend to set high standards for themselves, and manage their responsibilities well.

On the other hand, low scorers (below a T score of 40) are viewed as *not* accepting responsibilities well. They are considered undependable, untrustworthy, and lacking in integrity. The low-Re person is usually viewed as not having leadership potential because he or she lacks social concern and interest in others.

High scores on the Re scale in one's therapy patient can provide some reassurance that the client is likely to approach his or her relationships and daily activities with more self-confidence and social concern than people who make up the lower end of the distribution of Re scores. Low scorers, on the other hand, are likely to be more unconventional in their approach to others and too caught up in their own turmoil to concern themselves with "doing what is the right thing" with regard to others. Low-Re clients are often those who are likely to behave in selfish, nonsocially oriented ways. They may require more assistance from the therapist in defining the boundaries of reality and in seeing the social consequences of their behavior.

Social Responsibility Scale (*Re*)

In another product of their inquiry into political participation, Gough et al. (1952) used methods similar to those used in the development of *Do* for the construction of *Re*.

For samples of high school students and college members of fraternities and sororities, nominations by peers, teachers, or a high school principal identified individuals who rated as high in "a ready willingness to accept the consequences of [one's] own behavior, dependability, trustworthiness, and a sense of obligation to the group" (Gough et al., 1952, p. 74). Some effort was made to prevent the influence of extraneous characteristics, such as friendliness and popularity, on ratings of social responsibility, but it appears likely that the nominations were to at least some degree confounded with intelligence. The 30 items of *Re* for the MMPI-2, 6 keyed True, 24 False, form a subset of the 56-item Responsibility scale (*Re*) of the CPI.

The results of research with the CPI version of *Re* are mixed, with studies based on

ratings of responsibility faring less well than those comparing groups based on status or performance criteria (Megargee, 1972). Studies involving antisocial and delinquent groups have been more consistently supportive. The MMPI/MMPI-2 version of *Re* has stimulated very little research, and none that has illuminated the construct measured by this version of the scale. More useful in this respect is the pattern of correlations with other MMPI scales, with moderate positive correlations being found with scales measuring academic achievement, intellectual efficiency, tolerance, and control, and moderate negative correlations with scales measuring impulsivity, hostility, antisocial attitudes, and prejudice. The correlates relating to intelligence appear, at least in part, to be an artifact both of the samples and the peer nomination methodology of scale development. An unusual and interesting correlate of *Re* is Brozek's (1955) Aging scale (*Ag*), consisting of items showing age differences in samples of high-ability college and middle-aged men. This correlate would tend to support the observations of Caldwell (1988) and Duckworth and Anderson (1986) that *Re* scores tend to increase with age. The picture that emerges from an examination of the circumstances of its development, *Re* research to date, as well as the scale's internal MMPI/MMPI-2 correlates, suggests that the high *Re* scorer is a conventional and conforming but tolerant and even-tempered person who has benign expectations of others, exhibits self-control, is a "team player," and is able and willing to pledge allegiance to the collectives of which he or she chooses to be a part. *Re* appears to measure a form of responsibility that is most likely to be manifested in institutional settings where creative demands are low. The institution may be as small as a family or club or as large as a multinational corporation. The high *Re* scorer appears to be one whose performance and achievement are best manifested in structured settings that place a premium on cooperation with others, persistence, and a "duty-bound" variety of conscientiousness. The core construct of *Re* appears to be one of *dutifulness*. Thus, the responsible person is one on whom others can depend to observe and support the customs, norms, policies, and procedures, and advance the goals of the institution with which the individual identifies. This would account for the wide use of *Re* in employment screening (Butcher & Williams, 1992).

Duckworth and Anderson (1986) have put forward a conception of *Re* (and one that has been cited with at least some measure of approval by Caldwell, 1988; Graham, 1990; and Greene, 2011) that is similar to that offered here, but couched in terms of values.

Duckworth and Anderson (1986) maintained that *Re* “measures the acceptance (high score) or rejection (low score) of a previously held value system” (p. 279) and noted that *Re* likely does not assist in identifying the nature of the particular value system that the person holds, is in transition from, or spurns. For persons under age 25, parental values are assumed to be those in question, whereas for persons over age 25, the person’s current value system is not assumed to reflect parental values. According to this view, *Re* scores tend to decline during periods of transition, as previously held values become subject to increased reflection, examination, and questioning. Such periods may occur as a result of other life transitions, such as leaving home to attend college, the birth of a child, the recognition of a need to seek membership in a congregation for the benefit of a child’s religious upbringing, a death in the family, shifts in occupation or employment (e.g. from sales to service), following natural disasters, and similar events. Such transitions often stimulate questions of value in their wake, just as they may lead to emotional upheaval, uncertainty, and weakened controls. Similarly, scores may fall as the person becomes disenchanted with the goals and practices of the organization to which he or she belongs. Some of the research with delinquents reviewed by Megargee (1972) suggests that the lower ranges of *Re* are more discriminating than the higher ranges. For example, in one study reviewed, a sample of delinquents with and without actual court contact showed mean *T*-scores of 31 and 38, respectively. Duckworth and Anderson (1986) reported ranges consistent with this supposition. They stated that persons with elevations [of *T*-50–65] tend to accept their present value system and intend to continue using it. Persons with scores of 40 to 50 are questioning their present value system and those below 40 are rejecting their most recently held value system.

(Duckworth & Anderson, 1986, p. 279)

Guidelines for interpreting *Re* scores greater than *T*-50 need further exploration and research. It appears likely, however, that as scores of about *T*-60 are exceeded, the dispositions of high *Re* scorers may be less adaptive than scores of persons closer to the average range. Duckworth and Anderson speculated that higher ranging scores may be associated with a lack of imagination and an excessive, and perhaps excessively rigid, orientation to “oughts and shoulds,” giving rise to attitudes that a high *Re* scorer’s associates may find annoying. Similarly, scorers in this range may be overly quick to

identify with authority, regardless of its moral/ethical standing, and to sacrifice the interests of others, both within and outside of the organization in the pursuit of narrow organizational goals. For example, one would expect the “company man” to have a considerably higher *Re* score than the “whistle-blower,” even though both might be seen as socially responsible.

Among the low *Re* scores studied by Graham et al. (1999), problems with substance abuse and dependence were especially prominent, and many of these outpatients had histories of one or more arrests. They were seen in largely antisocial terms, but also as resentful, suspicious, mistrustful, having family problems, and stormy relationships more generally. The ACL correlates found by Hoffman and Pietrzak (2012) for the high *Re* scoring normal adults portray them as clear-headed and realistic, but careful if not overly cautious, sober, restrained, and compliant if not obedient.

Re SCALE(Social Responsibility Scale)

The Re scale originally was developed to determine the social responsibility of a person. That is, persons receiving high scores on this scale were seen as socially responsible, willing to accept the consequences of their behavior, trustworthy, and dependable, while persons receiving low scores were seen as socially irresponsible. We have noted however that persons receiving low scores could be equally as socially responsible as persons receiving elevated scores. Instead of social responsibility then, we feel this scale measures the acceptance (high score) or rejection (low score) of a previously held value system.

For persons under age 25, an elevation on this scale ($T = 50$ through 65) indicates that they accept in general the value system of their parents. A score in the 40 through 50 range usually indicates that the person is questioning the parental value system (a typical procedure for college students and for those mental health clients going through a traumatic life change). Scores below 40 usually indicate that the person is not just questioning but actually is rejecting the parental value system.

One caution must be noted. Many people tend to presume that a person is showing acceptance or rejection of white middle class values by his/her score on the Re scale. What this scale seems to be showing for this below 25 age group is acceptance or rejection of the parental values which

may or may not be those of the white, middle class. For example, Black ghetto-reared college students may receive low scores on this scale because they are rejecting the ghetto values with which they were reared and now are accepting white middle class values. Thus, to tell accurately what values are being accepted or rejected, one must know the person's background.

For persons above the age of 25, interpretation of this scale is based upon the person's present value system which may or may not be similar to the parents. Persons with elevations on the Re scale ($T = 50$ through 65) tend to accept their present value system and intend to continue using it. Persons with scores of 40 through 50 are questioning their present value system and those below 40 are rejecting their most recently held value system. An illustration of this is a 40 year old male with a Re score of 35. He had been reared with one value system (his parents') which he had rejected in his early 20s. Now at age 40, he was re-evaluating his own value system and felt that the values of his parents (those rejected 20 years previously) now were more valid for him than those he had held more recently.

For people of all ages, the higher a score above 65 on the Re scale, the more rigid a person seems to be in his/her acceptance of values and the less willing to explore other values.

As one examines the items and the intercorrelations of this scale with other scales, a consistent picture of a person with a high score emerges.

High scorers report that they had little trouble with authorities as they were growing up. They answer false to such items as "In school I was sometimes sent to the principal for cutting up" and "My parents have objected to the kind of people I went around with." This self-report receives some support from Re's $-.48$ correlation with the obvious Psychopathic Deviate Scale (Swenson et al., 1973).

Part of their comfort with authorities may be based on the fact that they seldom admit to taking risks. Seven of the 32 items on this scale indicate a lack of interest in creating excitement. They answer true to "I have never done anything dangerous for the thrill of it" and false to "I enjoy a race or game better when I bet on it."

This conservative approach to life does not appear to be related to fear but rather to a lack of interest in this kind of stimulating situation because they report that they feel comfortable with a variety of other situations that could produce anxiety. They answer true to "I do not dread

seeing a doctor about a sickness or injury" and "I usually work things out for myself rather than get someone to show me how."

The items concerning not taking risks seem to support the presence of a control factor in high Re people's behavior. This also is supported by a correlation of $-.53$ with Impulsivity and $-.50$ with Neurotic Under-control scales (Swenson et al., 1973),

High scorers on Re also report that they expect others to be positive in their behavior. They answer false to "A large number of people are guilty of bad sexual conduct" and "I have often found people jealous of my good ideas, just because they had not thought of them first." This also is supported by Re's correlation of $-.49$ with the Pr scale and $.52$ with the K scale (Appendix C).

This would seem to be one scale on which a certain type of good student would get high scores. This would be the student who reports liking school since Re correlates $.61$ with academic achievement, $.51$ with intellectual efficiency, $.51$ with intellectual quotient, and $.51$ with teaching potential (Swenson et al., 1973).

All of these factors together indicate someone who is confident, even-tempered, non-pretentious, comfortable with authority, and competent in academic areas, with little need to pursue adventure.

While high scorers have many strong points, several defects are possible. They may be unimaginative and non-creative. This is particularly likely to be true if scales 7 and 8 are below 45 T-score points. Their lives may be controlled by a considerable number of "ought to's" with which they are comfortable but which could annoy other people who have to work with them. That is, they may expect others to live up to their standards and be as comfortable with them as they are. Consequently they may have difficulty understanding why others cannot or will not perform as they do.

In addition to interpreting the Re scale alone, in certain instances shown in the Re and Pr combination summary, pp. 292-293, considering the Re scale in relationship to the Pr (prejudice or rigid thinking) scale is helpful. At first glance the Re and Pr scales would appear to be positively correlated; that is, those who question their previous values (low Re) also would be open to alternate viewpoints (low Pr). Similarly, those who wholeheartedly accept their previous values (high Re) would not be open to alternate viewpoints (high Pr). Certainly these

combinations do appear; however, other combinations also appear. Specifically, at least one segment of people who are questioning their previous values (low Re) (they usually consider themselves to be "liberal" thinkers) are not tolerant of others (high Pr), particularly others who accept the more traditional American value system. Apparently, these people are not as liberal as they believe themselves to be, at least about others who believe differently than they do.

Conversely, some people who accept their middle-class background with all its implications (high Re) also are able to listen to alternative beliefs held by others (low Pr). These people appear to have taken a position for themselves, but they are able to allow others to have their own positions.

If, however, the Re scale is above 65 T-score points and the Pr is low, the person's tolerance may be a willingness to let others express their beliefs as long as the others are responsible with these beliefs.

Interestingly, the Re scale tends to be correlated with age; the older the person, the higher the Re scale tends to be. We usually find the Re scale low for college students as they question how they were reared and some of the values of their parents.

GENERAL INFORMATION

1. The Re 32-item scale was developed by Gough (1952) to measure social responsibility.
2. Social responsibility was defined by Gough as the willingness to accept the consequences of one's own behavior, dependability, trustworthiness, and sense of obligation to the group.
3. Gough used the "peer nomination" method with this scale, asking college and high school students to choose the most and least responsible members of their groups. The MMPI items that differentiated between these two groups were the basis for the scale.
4. Instead of measuring social responsibility, the Re scale seems to measure how much the person accepts the values with which he/she was reared. Persons below age 25 who score high on this scale tend to accept their parents' values. When people question or reject the values of their parents, they usually score low on the Re scale.

Persons above age 25 who score low on this scale may be rejecting their most recently held value systems which may or may not be the same as their parents.

5. Heppner and Anderson (1985) have found that ineffective problem solvers were significantly lower on this scale than effective problem solvers.

SUMMARY OF Re SCALE INTERPRETATIONS

<i>T-Score</i>	<i>Below Age 25</i>	<i>Over age 25</i>
<i>40 or below</i>	This person tends to deny below the value system of his/her parents. Such a person may have substituted another value system for the paternal one.	This person tends to deny his/her most recently held value system (which may be different from the parents*.)
<i>40 thru 50</i>	People in this range tend to question their parents' values. They may be exploring alternative viewpoints. Their values seem to be in flux.	People in this range tend to be questioning their most recently held value system and are usually exploring different values.
<i>50 thru 65</i>	People with scores in this range tend to accept their parents' values. The higher the score in this range, the more the person has accepted these values.	A person with a score in this range tends to accept his/her present value system. The higher the score, the more the person has accepted these values.
<i>65 or above</i>	The higher a score is above 65, the more rigid a person seems to be in	Same as below 25

his/her acceptance of values and the
less willing to explore other values.

Mt–College Maladjustment

- Kleinmutz, 1960
- 41 items designed to discriminate between emotionally well-adjusted and maladjusted college students
- constructed on 40 adjusted students compared to 40 maladjusted students

T-Scores > 65 are indicative of individuals who:

1. are ineffectual, pessimistic, anxious and worried
2. have a tendency to procrastinate
3. have somatic complaints
4. feel that life is a strain

T-Scores < 40 are indicative of individuals who:

1. are optimistic, conscientious, and relatively free of emotional discomfort

College Maladjustment Scale (*Mt*);

Keane et al.'s Post-Traumatic Stress Disorder Scale (*PK*);

and Schlenger and Kulka's Post-Traumatic Stress Disorder Scale (*PS*)

Supplemental Scales: *Mt*, *PK*, and *PS*

Items:

College Maladjustment (Mt): 41 items; 28 keyed True

Post-Traumatic Stress Disorder–Keane (PK): 46 items; 38 keyed True

Post-Traumatic Stress Disorder–Schlenger (PS): 60 items; 47 keyed True

Major Internal Correlates of all three scales (all > .85): Scales A, 7, and 8, *D1*, *D4*, *D5*, *D-O*, *Sc4*, *ANX*, *DEP*, *DEP1*, *WRK*, *NEGE*, *RCd*.

Most Useful Comparisons: Caldwell (June 26, 1999, personal communication) has suggested that scores on the PTSD scales be required to exceed scores on A before diagnoses of PTSD are entertained.

Description/Interpretation: Scales *Mt*, *PK*, and *PS* are described together because they contain virtually identical variances. They are mutually intercorrelated at .90 or greater, and all correlated with A, *RCd*, and Scale 7 (raw) to the same degree (Greene, 2011). Thus, these scales are all saturated with the First Factor, and none have features that reliably set one apart from the others, save that *PK* may be scored completely within the first 370 items, making scores on this scale available for the short form of the MMPI-2. *PK* and *PS* are highly similar, containing 26 items in common.

Kleinmuntz (1960, 1961a, 1961b) developed the *College Maladjustment (Mt)* scale to identify college students with emotional problems that led them to seek treatment at a university mental health clinic. The item responses of students who sought counseling for emotional problems and remained for three or more sessions were compared with those of students referred to the same clinic for routine mental health screening for a teacher certification program, and who reported no previous treatment for mental health problems.

Keane, Malloy, and Fairbank (1984) developed their Post-Traumatic Stress Disorder scale (*PK*) by testing 100 male VA Vietnam combat veterans for whom diagnoses of Post-Traumatic Stress Disorder (PTSD), often among other concurrent diagnoses, had been established on the basis of structured interviews and psychophysiological measurements. They compared their responses with those of 100 veterans who carried diagnoses other than PTSD. Schlenger and associates (Schlenger & Kulka, 1987; Schlenger et al., 1989) compared the item endorsements of Vietnam veterans diagnosed with PTSD (without concurrent diagnoses) and nonpatient Vietnam veterans.

There are both empirical and conceptual reasons to doubt the utility of these

two PTSD scales for diagnosis. The chief empirical problem resides in the limited research demonstrating incremental validity for *PK* or *PS* over any of several other scales with which they share substantial variance (e.g., *A* or *RCd*; however, see Wolf et al., 2008). There is also no evidence that any of these scales satisfactorily discriminates patients with PTSD diagnoses from those with major anxiety and depressive disorders. More troubling, the status of the diagnosis of PTSD itself is not free of controversy (Young, 1995). Apart from relatively minor terminological differences used to describe them, the symptoms of PTSD are typically indistinguishable from those of better-established mood and anxiety disorders. Thus, differential diagnosis must be reckoned on the basis of etiology (i.e., putative trauma) rather than on presenting symptomatology.

Furthermore, the causal relationship between the symptoms of PTSD and reports of traumatic events is not established (e.g., Yehuda & McFarlane, 1995), nor is the temporal stability for recall of traumatic events, even when these are combat-related (Southwick, Morgan, Nicolaou, & Charney, 1997). Litz, Orsillo, Friedman, Ehlich, and Batres (1997) reported that in a sample of Somalia peacekeepers, noncombat factors such as a lack of pride in military service and frustration with the mission were as important in predicting symptoms of PTSD as was combat experience. Presuming that a traumatic event is the etiological factor may shape the way that clinicians and patients construe familiar symptoms of depression, anxiety, panic, and so on through confirmatory bias. Furthermore, such presumption may shift attention away from other etiological factors (e.g., genetically influenced predispositions) that have been established as diatheses for such symptoms. Among veterans of military service, the population on which the vast majority of PTSD research has been conducted, the potential etiological influence of disability compensation has received inadequate research attention. Pending the clarification of these empirical and conceptual issues, the clinical utility of *PK* and *PS* will remain uncertain. These scales are discussed more extensively in Friedman et al. (2001).

These three scales are discussed together because of their extensive shared variance; all are intercorrelated in the .90s. All are saturated with the major source of variation within the MMPI-2 item pool, the first factor. They show considerable item overlap and, in psychiatric samples, are intercorrelated with each other and with *A* and *Pt* (non-*K* corrected raw scores) at > .90. As a result, all may be interpreted as global indexes of the individual's current level of distress, maladjustment, or psychopathology. Kleinmuntz (1960, 1961a) developed the College Maladjustment scale (*Mt*) to identify college students with emotional problems of sufficient severity to impel them to seek treatment at a

university mental health clinic. The item responses of students who sought counseling for emotional problems and remained for three or more sessions were compared with those of students referred to the same clinic for routine mental health screening for a teacher certification program, and who reported no previous treatment for mental health problems. Forty-three items discriminated the maladjusted from the apparently adjusted students, of which 41 are retained in the MMPI-2; 28 items are keyed True, 13 False. In a follow-up study, Kleinmuntz (1961b) found that *Mt* failed to adequately predict adjustment problems among entering college students during their first year and concluded that it is best suited to identifying current, as opposed to future, maladjustment. On the basis of *Mt* content, Kleinmuntz (1960) characterized the high scorer as an “ineffectual, pessimistic, procrastinating, anxious and worried person who tends to somatize and who finds that much of the time life is a strain” (p. 210). Low scorers, by contrast, would be considered effective, optimistic, conscientious, and free of emotional discomfort.

The similarity of the adjusted student group to groups that were provided an incentive to respond in a self-favorable manner to the items (e.g. Cofer et al., 1949) may tend to inflate scores on *Mt* in persons inclined to modesty concerning their strengths, virtues, and other positive features of outlook, character, and demeanor. By contrast, scores may be suppressed by an inclination to claim such attributes. Thus, high *K* scores may suppress, and low *K* scores inflate, *Mt* scores.

Given the extensive shared variance between *Mt* and better established markers for general maladjustment, such as *A* and *Pt* (non-*K*-corrected), and the lack of empirical data demonstrating any incremental advantages over the latter scales even in college or university settings, the continued use of *Mt* has little or nothing to recommend it. The two PTSD scales differ primarily in terms of the contrast groups used in their development. Keane et al. (1984) compared the items of 100 male VA Vietnam combat veterans for whom diagnoses of PTSD, often among other concurrent diagnoses, had been established on the basis of structured interviews and psychophysiological measurements, with 100 veterans who carried diagnoses other than PTSD. The 49 items separating these groups, of which 46 remain in the MMPI-2, constitute *PK*. Thirty-eight items are keyed True, eight False. The empirical correlates found by Graham et al. (1999) to describe high *PK* scorers were, not surprisingly, identical to those found for high *A* scorers in most major respects.

Schlenger and associates (Schlenger & Kulka, 1987; Schlenger et al., 1989) compared the item endorsements of Vietnam veterans diagnosed with PTSD (without concurrent diagnoses) and non-patient Vietnam veterans. They found 60 items that differentiated the two groups. These items constitute *PS*, of which 47 are keyed True, 13 False. Thus, whereas the development of *PK* followed a method reminiscent of that used in the construction of the MacAndrew (1965) and Rosen (1962) scales, *PS* issued from the more conventional criterion-normal control

contrast method. Despite these differences in development, the two scales are correlated to the extent allowed by their reliabilities and share 26 items in common. One could fairly consider the latter set of items as a better validated measure of PTSD than either of its parent scales. However, a scale comprising these 26 items continues to correlate at $> .90$ with A and Pt (non- K -corrected), indicating that it contains little or no specific variance for PTSD.

It is thus doubtful that either of the PTSD scales may be used to contribute to the question of diagnosis. There are both empirical and conceptual reasons for doubts concerning the utility of these scales in this context. The chief empirical problem resides in the absence of research demonstrating incremental validity for PK or PS over any of several other scales with which they share virtually all of their variance. A study by Watson, Juba, Anderson, and Manifold (1990) found only a tenuous relationship between PK scores and a history of trauma in a sample of normal and patient Vietnam veterans. Thus, there is an urgent need for research comparing the diagnostic efficiency of the PTSD scales with older scales, such as Welsh's A . As one strategy for coping with the problem of the shared variance among the A , non- K -corrected Pt , Mt , PK , and PS scales, A. B. Caldwell (personal communication, June 29, 1999) has suggested scores on the PTSD scales be required to exceed scores on A before diagnoses of PTSD are even entertained. Although at least minimally plausible, this suggestion also requires empirical investigation. Another empirical question that has received too little investigation concerns the specificity and positive predictive value of PK and PS , especially when traumas other than those related to military combat are at stake. Finally, in a sample of Vietnam veterans, PK failed to discriminate those with and without a diagnosis of PTSD (Van Atta, 1999), and there is little evidence that either of the PTSD scales contributes to the discrimination of patients with anxiety disorders and patients with known traumatic histories, but the research available to date is not encouraging (e.g. Miller, Goldberg, & Streiner, 1995). In any event, and for reasons that remain obscure, PS , which was included in the first edition of the MMPI-2 *Manual* (Butcher et al., 1989), was dropped in its most recent edition (Butcher et al., 2001).

Also troubling is that the status of the diagnosis of PTSD has itself not been free of controversy (Young, 1995). Apart from relatively minor terminological differences used to describe them, the symptoms of PTSD are typically indistinguishable from better established mood and anxiety disorders, at least within the context of the MMPI/MMPI-2. This circumstance has necessitated that the differential diagnosis be reckoned on the basis of etiology (i.e. putative trauma) rather than presenting symptomatology. Yet the causal relationship between the "symptoms" of PTSD and reports of traumatic events is not established (e.g. Yehuda & McFarlane, 1995), and neither is the temporal stability for recall of traumatic events themselves, even when these are combat related (Southwick, Morgan, Nicolaou, & Charney, 1997). Moreover, Litz, Orsillo, Friedman, Ehlich, and Batres (1997) reported that in a sample of Somalia peacekeepers, noncombat factors, such as a lack of pride in military service and

frustration with the mission, were as important in predicting symptoms of PTSD as was combat experience. The presumption of a traumatic event as the etiological factor may not only shape the way familiar symptoms of depression, anxiety, panic, and so on are construed by both patients and clinicians so as to create confirmatory bias, it also tends to shift attention away from etiological factors, such as genetically influenced predispositions, that are better established as diatheses for such symptoms. Among veterans of military service, the population on which the vast majority of PTSD research has been conducted, the potential etiological influence of disability compensation has received inadequate research attention, although many reports (Franklin, Repasky, Thompson, Shelton, & Uddo, 2003; Frueh, Gold, & de Arellano, 1997; Frueh, Smith, & Barker, 1996; Gold & Frueh, 1999; Grubaugh, Elhai, Monnier, & Frueh, 2004; and Tolin, Maltby, Weathers, Litz, Knight, & Keane, 2004) indicate that compensation-seeking veterans obtain higher scores on one or more of the over-reporting scales and indices than do non-compensation-seeking veterans. Even this finding is not uniform, however (see, e.g. DeViva & Bloem, 2003; and Tolin, Steenkamp, Marx, & Litz, 2010). Pending the clarification of these empirical and conceptual issues, the clinical utility of *PK* and *PS* will remain most doubtful.

The College Maladjustment (Mt) Scale

(Kleinmuntz)

Therapists or counselors working in a college counseling setting are often at a loss to evaluate the nature and extent of problems being experienced by college students seeking help. Not only are the prospective student-clients manifesting symptoms of psychological disorder or personality problems, but they may also be experiencing a great deal of situational turmoil that is sometimes difficult to separate from more longstanding pathology. For example, many college students experience transitional problems related to working through autonomy and independence issues with their parents, or becoming involved in peer relationships can cause them great, though perhaps temporary, discomfort. As a result of turbulent situational problems, it may be difficult for the clinician to gain an accurate assessment of the individual.

The use of a college-specific assessment measure within the MMPI-2 might aid the clinician in obtaining an appropriate appraisal of students' problems.

One measure developed to assess college maladjustment, the Mt scale developed by Kleinmuntz, might be a valuable addition to the college counselor's initial assessment strategy because it provides a specific appraisal of college students.

Kleinmuntz (1961) developed the Mt scale as an aid in discriminating emotionally adjusted college students from those who are maladjusted. The items for the scale were derived by contrasting maladjusted male and female students

(obtained from a student counseling clinic) who were seen in therapy for at least three sessions from 40 male and female well-adjusted students (students being evaluated in the context of a teacher certification program). In the original scale development 43 items were identified that separated the groups. Items were keyed so that endorsement increased the probability that the individual was in the maladjustment group. The MMPI revision process (see Butcher et al., 1989) eliminated 2 items on the Mt scale; consequently, the revised version of the scale on MMPI-2 contains 41 items.

The Mt scale has been shown to have high test–retest reliability. Kleinmuntz (1961) reported a test–retest reliability of 0.88; Moreland (1985) reported 6-week test–retest correlations ranging from 0.86 for females to 0.89 for males; and Butcher et al. (1989) reported 1-week test–retest correlations of 0.91 for males and 0.90 for females. The Mt scale is thought to measure severe psychopathology in college students (Lauterbach, Garcia, & Gloster, 2002; Wilderman, 1984), and research has addressed the question of how effectively the scale predicts future emotional problems. Kleinmuntz (1961) concluded that the scale is more appropriate for detecting existing psychopathology than for predicting future emotional problems. Barthlow, Graham, Ben-Porath, and McNulty (2004) conducted a construct validity study of the Mt scale, reporting that a factor analysis of the scale revealed three main factors:

1. “Low Self Esteem,” or the tendency to lack self-confidence and to make negative comparisons with others
2. “Lack of Energy,” including such content as feeling tired and having difficulty starting to do things
3. “Cynicism/restlessness,” including themes such as having ideas that are too bad to talk about, and restlessness

Students who score high on the Mt scale are viewed as being generally maladjusted, anxious, worried, and ineffective in dealing with current situations, tending to procrastinate rather than to complete tasks, and tending to have a pessimistic, negative outlook on life.

The college counselor whose counselee has high Mt scores needs to be aware that the student is reporting substantial psychological problems and probably requires a treatment program that addresses the significant personal problems and goes beyond simple academic counseling.

Summary

This chapter has presented information about several MMPI-2 supplementary

scales that have relevance and potential utility in treatment-oriented assessment.

The three widely used substance abuse indicators (MAC-R, APS, and AAS) were described and illustrated. The MAC-R and APS scales measure addiction potential, an important assessment concern in most pretherapy evaluations, while the AAS assesses the extent to which the client is willing to acknowledge substance abuse problems. Other measures that provide valuable symptomatic information were described, including the Ho scale, the MDS scale, and the PTSD scale. Three measures that address several problems common to many therapeutic settings were described. The Es scale, although developed to provide a measure of treatment potential, actually provides more information about a person's present ability to tolerate stress. Low scores on Es appear to reflect an inability to deal effectively with current problems. The Re scale can provide the clinician with information about how a client assumes responsibility and conforms to the values of society. Finally, for clinicians working in college counseling settings, the Mt scale might provide a perspective on the level of maladjustment experienced by college students who seek counseling.

In the next chapter, we turn to an interpretive approach that emphasizes the client's acknowledgment of problems through his or her response to the test item content—an approach that is very different from the traditional MMPI-2 test development strategies.

PK—Post Traumatic Stress Disorder Scale

- Keane, Malloy, & Fairbank, 1984
- 60 items that measure PTSD symptoms
- scale constructed by comparing male VA patients with various Axis I diagnoses who had PTSD symptoms to male VA patients with various Axis I diagnoses who did not have PTSD symptoms
- need to have other measures to help in identifying subgroups of men and women suffering from PTSD
- still being refined

The Assessment of Posttraumatic Stress Disorder (Keane PTSD Scale)

Many clients entering psychotherapy have recently experienced trauma of some sort such as failed relationships, an accident, military or terroristic trauma, and so forth. Moreover, a large number of people entering therapy have experienced traumas in the past that linger on as important and continuing sources of

concern for the person. The evaluation of past trauma is usually an important step in the early stages of treatment.

One MMPI-2 scale, the Post-Traumatic Stress Disorder Scale (PTSD-Pk), was developed by Keane, Malloy, and Fairbank (1984) and has received a great deal of research attention in the past 20 years (Penk et al., 2006). In the development of the PTSD scale, the authors followed an empirical scale construction strategy. They used a group of 100 male veterans who had been diagnosed with PTSD in contrast with 100 male veterans having other psychiatric problems. They obtained 49 items that significantly discriminated the PTSD group from the general psychiatric sample. They found that this scale had an 82% "hit rate" in the classification of veterans with PTSD. The Pk shows a high degree of relationship to other anxiety measures on the MMPI-2 such as the Pt and is negatively correlated with the K. The Pk has been found to measure psychological distress, although not necessarily acute problems. The scale is also often elevated in samples of chronic psychiatric patients (Arbisi, 2006). (For a comprehensive review of the use of the MMPI-2 with PTSD clients see Penk et al., 2006.)

PS—Post Traumatic Stress Disorder Scale

- Schlenger & Kulka, 1987
- 46 items measuring unwanted disturbing thoughts, lack of emotional control, and feeling misunderstood and mistreated
- scale constructed by comparing 60 male Vietnam vets with PTSD to 60 male Vietnam vets without PTSD

- still being refined

T-Scores > 65 are indicative of individuals who:

1. have intense emotional distress and anxiety
2. have sleep disturbances
3. experience guilt and depression
4. report unwanted disturbing thoughts
5. fear a loss of emotional and cognitive control
6. feel misunderstood and mistreated

T-Scores < 40 are indicative of individuals who:

1. do not report emotional distress, anxiety, guilt or depression
2. do not report unwanted disturbing thoughts
3. do not fear a loss of cognitive or emotional control
4. do not feel misunderstood or mistreated

GM—Masculine Gender Role and GF—Feminine Gender Role

- Peterson, 1989
- GM scale consists of 47 items that were endorsed in the scored direction by a majority of males but only 10% (or less) of females
- GF scale consists of 46 items that were endorsed in the scored direction by the majority of females but only 10% (or less) of males

- 9 of the 47 GM items and 16 of the 46 GF items are on the MF scale

Supplemental Scales: *Gender Role–Masculine (GM)*

Items: 47; 19 keyed *True*

Major Internal Correlates: Scales *A*, 7, 8, and 0, *D1*, *D5*, *D-O*, *Hy-O*, *Si3*, *ANX*, *FRS*, *OBS*, *DEP*, *DEP2*, *LSE*, *WRK*, *TRT*, *NEGE*, *Mt*, *PK*, *PS*, *RCd*, *RC7*, all negative. *GM* overlaps *FRS* by 10 items, 6 on *FRS2*.

Most Useful Comparisons: Scale 5, *Mf1*, *Mf3*, *Mf6*, *Mf10*, *GF*, *FRS*

Description: Peterson and Dahlstrom (1992) developed the gender-role scales to serve as independent measures of masculine and feminine role identification. They sought to apply research and theory supporting a conception of masculinity and femininity as independent attributes of personality that could contribute to the understanding of both males and females. Using the MMPI-2 restandardization sample, items were selected for each of the gender-role scales if endorsed by at least 70% of members of one gender and by at least 10% fewer of the opposite gender. Items thus selected were then grouped into two scales. Those endorsed more commonly by men and less commonly by women comprise *GM*, a scale of 47 items (19 scored *True*; 28 *False*). Those with the opposite trend comprise *GF*, a scale of 46 items (15 scored *True*; 31 *False*). The aspiration of independence for *GM* and *GF* was substantially realized in that the scales were found to correlate at only $-.10$ in the restandardization sample (Peterson & Dahlstrom, 1992). Note from the Major Internal Correlates that *GM* is relatively saturated with the First Factor, with low *GM* scores corresponding to elevations of First Factor scales. This scale is unlikely to function well in patients with severe or active mental disorders, whether inpatient or outpatient, as scores will routinely be low in such cases.

Interpretation: High scorers tend to manifest traditional attributes of masculine strength, such as self-confidence; forthrightness; goal persistence; and freedom from worries, self-consciousness, and social inhibition. Fearlessness is a particularly strong component of the item content. Note that these attributes are somewhat culturally prescribed and stereotyped.

Supplemental Scales: *Gender Role–Feminine (GF)*

Items: 46; 15 keyed *True*

Major Internal Correlates: Negatively with Scale 9, *Pd2*, *Ma-O*, *ANG1*, *CYN*, *ASP1*, *ASP2*, *TPA2*, *DISC*, *MAC-R*, *AAS RC4* and, positively, with Scale 5, *Mf3*, *Mf6*, *D-S*, *Re*. *GM* overlaps (negatively) *DISC* by 9 items, and *Re* by 6.

Most Useful Comparisons: Scale 5, *Mf1*, *Mf3*, *Mf6*, *Mf10*, *GM*, *DISC*.

Description: See *GM*. Note from the Major Internal Correlates that *GF* is aligned with the Second Factor, with low *GF* scores corresponding to elevations on most Second Factor scales (e.g., Scale 9, *DISC*, *MAC-R*). As with *GM*, this scale is unlikely to function well in patients with severe or active mental disorders, whether inpatient or outpatient, as scores will routinely be low in such cases.

Interpretation: High *GF* scores are associated with traditional feminine attributes of social circumspection, agreeableness, trust, loyalty, and the avoidance of conflict and impropriety. Self-control and responsibility are particularly strong components of the item content. This set of attributes is somewhat culturally prescribed and stereotyped.

T-Scores > 65:

GM—male

- a) high self confidence
- b) strong persistence
- c) wide interests
- d) lack of fears

GM—females

- a) high self-confidence
- b) honesty
- c) willingness to try new things
- d) lack of worries

GF—male

- a) religiosity
- b) avoidance of swearing and cursing
- c) frankness in pointing out faults of others
- d) bossiness
- e) poor control over their temper
- f) susceptibility to abuse of alcohol and other nonprescription drugs

GF—female

- a) religiosity
- b) problems with substance abuse

High GM & Low GF

- 1. stereotypical masculinity

High GF & Low GM

- 1. stereotypical femininity

High GF & High GM

- 1. androgyny

Low GF & Low GM

- 1. undifferentiated orientation

Gender Role—Masculine (*GM*) and Gender Role—Feminine (*GF*)

Scales

In developing the gender-role scales, Peterson (1991; Peterson & Dahlstrom, 1992) sought to apply research and theory supporting a conception of masculinity and femininity as independent attributes of personality that could contribute to the understanding of both men and women. Her approach was intended as both a contrast and a supplement to the traditional bipolar measurement of masculinity–femininity embodied in the MMPI-2 *Mf* scale.

The availability of scales for the independent measurement of masculinity and femininity would enable the identification of androgynous (high scores on both scales) and undifferentiated (low scores on both) gender-role styles. That is, such scales would allow inferences regarding androgyny or a lack of gender-role differentiation, patterns that would otherwise be concealed by mid-range *Mf* scores. The ability to distinguish between androgynous and undifferentiated gender-role styles is, of course, of some significance clinically, as androgyny is typically aligned with favorable emotional adjustments, whereas a lack of gender-role differentiation is associated with more fragile and unstable adjustments.

Using the MMPI-2 re-standardization sample, items were selected for each of the gender-role scales if endorsed by at least 70 percent of the members of one gender and by at least 10 percent fewer of the opposite gender. Items thus selected were then grouped into two scales. Those endorsed more commonly by men and less commonly by women comprise the 47-item *GM* scale (19 items are keyed True, 28 False). Those with the opposite trend comprise the 46-item *GF* scale (15 True, 31 False). Peterson's aspiration of independence for *GM* and *GF* was substantially realized in that the scales were found to correlate at only $-.10$ in the re-standardization sample (Peterson & Dahlstrom, 1992) and $.05$ in a large psychiatric sample (R. L. Greene, personal communication, March 6, 1998). Among members of the same psychiatric sample, *Mf* and *GM* correlated at $-.39$ and $-.23$, for men and women, respectively; *Mf* and *GF* correlated at $.37$ and $.46$, for men and women, respectively.

Although Peterson (1991) found some differences between men and women in the characteristics empirically associated with *GM* and *GF* scores, most are similar. High *GM* scores are associated with traditional attributes of masculine strength, such as emotional stability; self-confidence; forthrightness; goal persistence; and freedom from fears, worries, self-consciousness, and social inhibition. These characteristics are substantially confirmed in the ACL correlates reported by Hoffman and Pietrzak (2012). The major MMPI-2 scale correlates include *Pt* (non-*K*-corrected), and *A* at $\sim-.80$, *Es* at $\sim.80$, and *FRS* at $\sim.70$, with which it shares 10 items, scored oppositely.

High *GF* scores tend to deny masculine interests and assert a feminine gender identity, and are associated with traditional feminine attributes of social circumspection, agreeableness, trust, loyalty, and the avoidance of conflict and impropriety. The ACL correlates of *GF* found for normal adults by Hoffman and Pietrzak (2012) included aggressive, rebellious, tough, and vindictive, all in a range of $-.24$ – $.25$. The major MMPI-2 scale correlates include *DISC* and *ASP* at $\sim-.50$, and *Re* at $.43$. The attributes associated with *GM* appeared to fit both men and women more comfortably than those of *GF*. Butcher et al. (1989) found that men with high *GF* scores appeared somewhat less

comfortable than women with high *GM* scores, being often described as bossy, faultfinding, and given to outbursts of temper; they were also more often described as religious and unlikely to engage in swearing. Somewhat surprisingly, both men and women with high *GF* scores were described as prone to misuse alcohol and nonprescription drugs. A few reports have found both *GM* and *GF* to be correlates of psychological well-being (Castlebury & Durham, 1997; Johnson, Jones, & Brems, 1996), but perhaps stronger in the case of *GM* (Woo & Oei, 2006). Peterson and Dahlstrom (1992) did not present empirical correlates for men or women scoring high or low on both *GM* and *GF*.

The gender-role scales have as yet to stimulate much research, and the correlates reported by Peterson and Dahlstrom (1992) are in need of replication, especially those that are counterintuitive like the abuse of alcohol and nonprescription drugs for *GF*. Nevertheless, these scales appear to serve a useful purpose, potentially confirming the usual meanings that attach to very high or very low *Mf* scores, and allowing tentative inferences concerning gender role when *Mf* scores fall into a middle range. Even in advance of further evidence bearing on the relations between *GM* and *GF* and genderrole correlates, the moderate to high correlations between these scales and *FRS*, *Es*, *LSE*, non-*K*-corrected *Pt*, *WRK*, *Si*, and *Do*, and *DISC*, *ASP*, *Re*, *MAC-R*, and *Pd2*, respectively, permit a glimpse of the general trend of correlates that are likely to be found for each, whether or not these may be seen to conform to gender-role expectations and stereotypes.

The alert reader will not have missed the apparent relationship between *GM* and *GF* and the two major sources of variance in the MMPI-2 item pool. That is, the correlates of *GM* appear substantially consistent with an absence of general maladjustment or subjective distress (first factor—low), whereas the correlates of *GF*, at least for women, reflect emotional and behavioral control (second factor—high). From this perspective, one can better appreciate how high *GF* scores for men may more readily conflict with common masculine role expectations than do high *GM* scores among women, i.e. women may more readily achieve a comfortable balance between personal ambition and those

traits such as loyalty and consideration that are necessary to maintain good relations with others. As in the case of other scales sharing considerable first-factor variance, *GM* is relatively sensitive to distortion through response style, with a bias toward overreporting psychopathology tending to suppress scores and under-reporting tending to elevate them.

Unfortunately, the utility of the gender-role scales does not extend to predictions regarding the respondent's pattern of leisure and occupational interests. Users of the MMPI long ago noted that *Mf* scores, even when relatively extreme, often afforded a misleading picture of interests. Because only about half of the *Mf* items carry

interest-related content, men may achieve high *Mf* scores and still endorse many more traditional masculine interests than traditional feminine interests. Similarly, women may achieve high *Mf* scores and still endorse many more traditional feminine interests than traditional masculine interests. The *GM* and *GF* scales do little to clarify this matter. In the MMPI environment, the Serkownek (1975) subscales for *Mf* provided scores for ascertaining the relative balance of masculine and feminine interests. However, these subscales were not retained in the MMPI-2. Martin and Finn (1992) developed new *Mf* subscales (scoring keys available in Friedman et al., 2001; Greene, 2000), and it is hoped that these will eventually become available for routine use. These subscales are described in detail in Chapter 5.

Note

1 Elhai, Ruggiero, Frueh, Beckham, and Gold, (2002) developed a new scale, *F_{ptsd}*, to discriminate simulated from genuinely reported PTSD in a sample of combat veterans. The results of subsequent validity studies on this scale have been mixed, with positive findings reported by Elhai, Naifeh, Zucker, Gold, Deitsch, and Frueh, (2004a; see also Elhai, Naifeh, Zucker, Gold, Deitsch, and Frueh, 2004b), and by Tolin, et al. (2010), and negative findings by Marshall and Bagby (2006).

^THIS SCALE IS STILL CONSIDERED EXPERIMENTAL IN NATURE; INTERPRET WITH CAUTION^

MDS - Marital Distress Scale

Marital Distress (MDS)

Items: 14; 8 keyed *True*

Major Internal Correlates: Scales *A*, *4*, *7*, and *8*, *D5*, *Pd4*, *Pd5*, *Pd-O*, *Sc1*, *DEP*, *FAM1*, *WRK*, *TRT*, *NEGE*, *Mt*, *PK*, *PS*.

Most Useful Comparisons: *Pd1*, *Sc1*, *FAM1*, *FAM2*. The emphasis in *MDS* is on current rather than past family problems, so it is informative to compare elevations with scales more biased toward family of origin such as *Pd1*.

Description/Interpretation: Developed by Hjermboe, Almagor, and Butcher (1992), who determined the items based on their correlations with the ratings of couples' marital relationships (those of both normal couples and couples in marital counseling).

High scorers report significant dysphoria and distress focused on relations within the family. *MDS* may not be suitable for patients not involved in committed relationships.

The availability of data gathered from couples in the course of the MMPI-2 restandardization project provided a suitable comparison group for a sample of 150 distressed couples involved in marital counseling. Test data for the distressed couples were gathered from 21 clinicians, most of whom practiced privately in the

Minneapolis-St. Paul area. A few practiced in Scottsdale, Arizona. An initial pool of potential items was selected on the basis of the strength of correlations between the 567 MMPI-2 items and scores on the 31-item Dyadic Adjustment Scale (DAS; Spanier, 1976) separately for the men and women in the marital counseling sample. The same correlations were then gathered from 392 of the couples from the re-standardization sample. Significant (.001) correlations were found between the DAS scores and 17 MMPI-2 items for the men and women of both the counselee and the restandardization normal couples. Of these 17 items, 2 were dropped for their failure to replicate in the 384 normal cross-validation couples and 1 was dropped for “extraneous content” (Hjemboe et al., 1992, p. 144), leaving a final scale of 14 items, of which 8 are keyed True, 6 False. The items tend to be dysphoric in tone, and *MDS* is correlated with *Pd*, *Pt*, *Sc*, *DEP*, *FAM*, *WRK*, *TRT*, *A*, *Mt*, and *PK* at $\sim .80$. Because *MDS* overlaps substantially with Scale 4 (eight items), *PdI* (Familial Discord; four items), and *FAM* (six items), Hjemboe et al. (1992) undertook multiple regression analyses to evaluate the relative value of the four scales in predicting DAS scores. *MDS* emerged as the best predictor in both their clinical and nonclinical samples. Further analyses evaluated the performance of these four scales in contingency tables with respect to hit rate, positive predictive value, and sensitivity. *MDS* alone exceeded the base rate in the overall accuracy of classification, and in achieving a better than chance level of positive predictive value. However, none of these scales identified more than half of the participants scoring in the distressed range of the DAS. In attempting to account for this apparent lack of sensitivity, Hjemboe et al. compared the DAS scores of the true-positive and false-negative cases and found, as expected, that the DAS scores were significantly lower (poorer adjustment) for the former group than for the latter group. One hypothesis that is consistent with this finding is that *MDS* scores may be suppressed by an overall tendency to underreport psychopathology. That the social desirability ratings of the nine *MDS* items for which such ratings are available (Butcher et al., 1989) average only 2.53 (where neutral desirability is 5.00) would seem to lend plausibility to this hypothesis.

Although *MDS* showed a higher than desirable false-negative rate and a lower than desirable true-positive rate at a *T*-score of 60 on the basis of an estimated rate of marital maladjustment in the general population of 18 percent, the level of *T*-60 did perform favorably in some of the other Hjemboe et al. (1992) analyses. These suggested that an even lower score (e.g. *T*-58) may improve predictive accuracy in outpatient and other settings having a higher base rate for problems in marital adjustment. On the other hand, in settings having a low base rate for persons of married (or the equivalent) status and/or a high base rate for general interpersonal conflict, the predictive accuracy of *MDS* could fall off sharply. Perhaps in recognition of this problem, Butcher (1993) suggested that *MDS* be interpreted *on/y* when the examinee is a member of a couple. Graham et al. (1999) found that their high *MDS*-scoring outpatients were depressed and interpersonally sensitive. They often had few or no friends, and tended to be

described in terms suggesting anger and resentment as well as dysphoria. The normal adult ACL correlates found by Hoffman and Pietrzak (2012) suggest confusion, dissatisfaction, and worry, pessimism, immaturity, bitterness, apathy, and low self-confidence. For some purposes, however, the clinician may wish to disregard this limitation. One virtue of the *MDS* is its focus on discord within current, as opposed to past, family relationships. In this respect, it may provide a useful contrast with *Pd*, which is biased toward discord within the family of origin. Thus, the two scales can be used configurally with *FAM* to help refine hypotheses involving family conflict.

The presence of relationship problems in patients entering therapy can be deterrents to progress. Relationship problems, especially those not disclosed in early treatment sessions, can be disruptive to the treatment process. Personality factors addressed by the MMPI-2 can provide valuable information as to potential problems or attitudes that might be coloring a client's relationships within his or her marriage.

Most of the research on using the original MMPI with couples in therapy involved exploring the personality profiles of husbands and wives using the traditional clinical scales. Studies of marital distress typically found that the *Pd* scale was the most frequently elevated scale among individuals experiencing marital problems (Hjemboe & Butcher, 1991). However, scale elevations on *Pd* are associated with many things other than just marital problems (e.g., anger control, impulsivity). With the publication of MMPI-2, research on couples in marital distress also found *Pd* to be the most prominent scale elevation, but one of the new content scales, Family Problems (*FAM*), was also found to be significantly related to marital distress. These scales were not originally developed to assess marital problems directly (Hjemboe & Butcher, 1991). Therefore, Hjemboe, Almagor, and Butcher (1992) developed an empirical MMPI-2 scale for assessing marital distress that focuses specifically on marital relationship problems. The Marital Distress Scale (*MDS*) is a 14-item empirically derived scale designed to focus upon marital problems. Items were selected that were strongly associated with a measure of marital distress, the Spanier Dyadic Adjustment Scale. This item content for *MDS* relates to marital problems or relationship difficulties. As one would expect, the *MDS* shows a higher degree of relationship to measured marital distress than either the *Pd* or the *FAM* (Hjemboe et al., 1992).

Couples who are having marital problems typically describe these concerns openly to the clinician in an interview. It is therefore not surprising that they might also have a high *MDS* score. However, the *MDS* might be most valuable in the treatment context when it provides information that the clinician does not know—that is, when the *MDS* is elevated in a mental health treatment setting when the person is reporting other mental health problems or when marital problems were not the reason for referral. The *MDS* can signal problems of which the client is unaware or at least not reporting in interview.

Ho - Hostility Scale

Supplemental Scales: *Hostility (Ho)*

Items: 50; 47 keyed *True*

Major Internal Correlates: Positive: *CYN*, *CYN1*, *RC3*, *AGGR*, *RC9*; negative: *Hy2*, *Pa3*, *S1*.

Most Useful Comparisons: See Major Internal Correlates.

Description/Interpretation: Developed by Cook and Medley (1954) to predict teachers' ability to get along with the students in their classes on the basis of their scores on the Minnesota Teacher Attitude Inventory (Cook, Leeds, & Callis, 1951). Cook and Medley describe high scorers as having "little confidence in [their] fellowman, . . . [seeing others] as dishonest, unsocial, immoral, ugly, and mean, and believ[ing] they should be made to suffer for their sins" (1954, pp. 417–418). The dimension of primary interest to the scale's developers was a sense of rapport between teacher and pupil. Given the pattern of item overlap between other MMPI-2 scales, the content of *Ho* emphasizes cynicism rather than hostility, although the latter is present as a strong secondary dimension. Han, Weed, Calhoun, and Butcher (1995) found four factors for *Ho* that they labeled *Cynicism*, *Hypersensitivity*, *Aggressive Responding*, and *Social Avoidance*, but these may tend to obscure the fundamental theme of *Ho*: People are no damn good. *Ho* may be of particular value in employment screening contexts. The *Ho* scale has functioned as a risk factor in many studies of cardiovascular disease, with increased mortality/morbidity associated with high scores (see, e.g., Barefoot et al., 1989; Williams & Barefoot, 1988). High scorers are cynical and suspicious but less hostile than hateful, and less angry than mean. Although clearly present in the item content, anger and hostility are more implicit than otherwise and take the form of resentment, antagonism, scorn, disdain, envy, and pleasure in the misfortunes of others. They embrace that kind of superiority wherein one derives vicarious pleasure at others' comeuppances ("Serves 'em right; they had it coming."), and sees others as at least as cynical as they are, as undeserving of understanding, and as needing to be corrected and put straight. They are thus stingy, withholding of credit, kindnesses, sympathy, and the benefit of the doubt in what they see as a dog-eat-dog world. In this sense, the high scorer is likely to be alienated and both emotionally and interpersonally isolated.

Low scores suggest the opposite characteristics of high scores, but without the implications of naivete, such as is often appropriate in the interpretation of very low scores on *RC3* and *CYN*, or very high scores on *Pa3*, for example.

Low *Ho* scorers are generous in their appraisals of others and desire to play well with them. They take into account the circumstances of their lives, are sympathetic to their suffering, and are quick with a smile and a kind word. They take the view that "We're all in this together," do not harbor grudges, are flexible and willing to live and let live, and maintain an appreciation that "There, but by the grace of God, go I." In this sense, and although they may or may not be especially empathic as regards the feelings and circumstances of others, low scores are likely to manifest a quality of accessibility, warmth, and readiness for rapport.

The Hostility scale (Cook & Medley, 1954) was developed on the basis of contrasts of teachers scoring low versus high on the Minnesota Teacher Attitude Inventory (MTAI; Cook, Leeds, & Callis, 1951), a 150 Likert item survey of teachers' attitudes toward students and career satisfaction that seeks to get at the teacher's sense of rapport, understanding, cooperation, and sense of common purpose with students. On the basis of a combined empirical-rational methodology, 50 items were selected to form *Ho*, of which 47 items are keyed True, 3 False. It positively overlaps *CYN* by 17 items (10 on *CYN1*; 7 on *CYN2*), *Si* by 9 (5 on *Si3*), Wiggins *HOS* by 8, *ASP* by 7 (all on *ASP1*), *AGGR* by 7, and *TPA* by 6 (4 on *TPA2*); and negatively overlaps *S* by 11 items (9 on *S1*), *K* by 8, *Hy* by 8 (7 on *Hy2*), and *Pa* by 5 (all on *Pa3*). The major MMPI-2 scale correlates of *Ho* include *CYN* at .91, and *S* and *K* at ~.85 (Greene, 2011). Han, Weed, Calhoun, and Butcher (1995) found four principal components: cynicism, hypersensitivity, aggressive responding, and social avoidance. Studies addressing the construct validity have been generally positive (e.g. Pope, Smith, & Rhodewalt, 1990; Smith & Frohm, 1985). Despite the extensive shared variance with *CYN*, emphasizing a more passive misanthropic alienation from others, *Ho* conveys a greater sense of *activated* enmity or antipathy toward them, with vengefulness and a willingness to engage others antagonistically, given the opportunity. Largely absent from the research literature following its creation, a resurgence of interest in *Ho* came with a report by Williams et al. (1980), which found a relationship between *Ho* scores and coronary atherosclerosis, and subsequently confirmed by Barefoot et al. (1989), and Shekelle et al. (1983). McCrae, Costa, Dahlstrom, Barefoot, Siegler, and Williams (1989) found an association between *Ho* scores and mortality from all causes. Other studies, however, have either failed to confirm these findings (e.g. Hearn, Murray, & Luepker, 1989; Leon, Finn, Murray, & Bailey, 1988, 1990), or reported equivocally (Friedman & Booth-Kewley, 1987). Illustrative of the status of the evidence of *Ho* in relation to CHD and mortality are the 25-year follow-up studies of physicians by Barefoot et al. (1983; *N* = 255), and by McCranie, Watkins, Brandsma, Sisson (1986; *N* = 478), in which the former investigators found *Ho* scores to be associated with both increased mortality and CHD, while the latter found *Ho* scores to predict neither. It may be that the differences in the outcomes in studies of *Ho* represent only random sampling fluctuations, as Friedman and Booth-Kewley (1987) have suggested, and Colligan and Offord (1988a) found significant overlap in distributions of *Ho* scores for normals, medical patients, and earlier CHD study participants. Another possibility is that, in relation to CHD, the *Ho* construct may be overly broad, and that only those components of the scale focused on cynicism, antagonism, hostile affect, and aggressiveness may show a robust relationship to CHD (Barefoot et al., 1989; Costa, Zonderman, McCrae, & Williams, 1986), or even that *Ho* be replaced by *CYN* in future studies of coronary disease (Mittag & Maurischat, 2004). *Ho* scores appear related to race, education, gender, SES, and self-care, with nonwhites, men, poorer, the less educated (Barefoot, Peterson, Dahlstrom, Siegler, Anderson, & Williams, 1991), and those with worse health habits (Leiker & Hailey, 1988) tending to achieve higher scores. Further, in evaluating scores on *Ho*, the clinician should be alert to scores on *K* (*K* x

Ho = $-.83$; Greene, 2011), and on the True/False balance of the protocol, as either or both elevations on *K* and a bias toward False responding will suppress *Ho* scores. Contrastingly, low *K* scores and/or a True response bias will inflate them.

In general, high *Ho* scorers tend to be cynical and mistrustful, seeing others as selfish, manipulative, morally corrupt, and undeserving of sympathy or understanding. They are quick to attribute malintent to others' actions, viewing them as deliberately hostile or provocative, and taking the position that others "deserve what they get." These trends are likely to be somewhat attenuated in women, with the latter tending to describe others in terms like "mean" and "ugly," and to appear more distressed, long-suffering, resentful, and unforgiving. Neither is likely to have many close friends. It is best to compare *Ho* scores with those on *ANG*, *CYN*, *TPA* (especially *TPA2*), and *AGGR*, as the relative elevations among these can usefully guide interpretive emphases. For example, when *ANG1* is highest among these, the emotional lability and hotheaded aspect of *Ho* would appear to be emphasized, whereas when *TPA2* and *AGGR* are comparably elevated with *Ho*, a more predatory and vindictive hostility is suggested.

The Ho Scale

The tendency of some clients to experience anger control problems can be an important factor in the therapy process. Therefore, gaining an indication of potential anger problems early in treatment can alert therapists to potential problems that could threaten progress. Cook and Medley (1954) developed the *Ho* scale as a measure of a person's ability to relate harmoniously to others, to establish interpersonal rapport, and to maintain morale in group situations. They developed the *Ho* empirically by contrasting groups of schoolteachers who had been judged to differ with respect to having the capability of getting along in the classroom with their students. High *Ho* scorers were teachers who were considered to be difficult to get along with interpersonally. In addition, high scorers were reportedly hostile and negative to their students and considered them to be dishonest, insincere, untrustworthy, and lazy.

Research on the *Ho* expanded its application with an entirely different population than the developmental sample—medical patients. The *Ho* became widely used as a measure of hostility in people with coronary disease (see Arbisi, 2006; Barefoot, Dahlstrom, & Williams, 1983), particularly as a measure of premorbid personality characteristics that were considered to be associated with later development of heart disease. People who have high levels of interpersonal hostility and cynical attitudes were thought to have a greater likelihood of developing hypertension than those having low hostility.

In the redevelopment of the *Ho* scale after the MMPI-2 was published, the scale required some modification since 9 of the 50 items on the scale were slightly reworded to make them more readable and contemporary. Thus, Han, Weed, Calhoun, and Butcher (1995) conducted a validation study of the revised items showing that the *Ho* scores were highly related to other MMPI-2 scales that measure cynicism and hostility (i.e., *CYN*, *TPA*, and *ASP*). In addition, high *Ho* scorers, based upon spousal ratings, were considered hotheaded, bossy, demanding, and argumentative. In interpretation, high-*Ho* clients are seen as possessing personality characteristics of cynicism and hostility. Low scores on the *Ho* are not interpreted as being low in hostility because only high point scores have been validated thus far.

PSY-5 Scales

The Personality Psychopathology Five (PSY-5) Scales

- Created by Harkness, McNulty, & Ben-Porath (1995) to coincide with the Big Five Personality Traits
 - they are models of traits designed to aid in personality description and to complement personality disorder diagnoses with quantitative dimensions
- the PSY-5 scales were created by first analyzing fundamental topics of the personality disorders in the DSM-III-R and normal personality trait terms
- Harkness & McNulty (1994) then collected and analyzed 603 psychological similarity matrices obtained from 201 participants to examine the internal structure of normal personality and personality disorders
- the results indicated a hierarchical structure

The upper level of the hierarchy is a five-dimensional model composed of:

- i. aggressiveness
- ii. psychoticism
- iii. constraint
- iv. negative emotionality/neuroticism
- v. positive emotionality/extraversion

PSY-5 Facet Subscales

Seeking to replicate the clinical utility of sub- or component scales for the MMPI-2 clinical and content scales, respectively, for the PSY-5 scales, Arnau, Handel, & Archer (2005) used principal components analysis to devise 13 facet subscales for them. Although mixed, subsequent evaluations of the reliability

and validity of these facet scales have been, on balance, discouraging (Jones, 2008; Quilty & Bagby, 2007; Wang, Zhang, Shi, Zhou, & Li, 2010), but they are nevertheless helpful for understanding the varieties of item content comprising the *PSY-5* scales.

Harkness, McNulty, Ben-Porath, and Graham (1999, 2002) developed the Psychopathology Five (PSY-5) scales as a strategy for assessing the “Big Five” personality dimensions for psychopathology from the MMPI-2 item pool. In the development of these measures, Harkness and his colleagues studied how laypeople classified or described the personality of others. The PSY-5 concepts, as defined by Harkness (1992), serve as summary concepts of the psychological distance—a measurement of how similar or different two objects or concepts seem to individual people when viewing others. These scales can provide useful summary personality dimensions that describe personality functioning that would be manifest through the course of therapy since they address persistent personality characteristics of the client.

The Personality Psychopathology Five (PSY-5)

The MMPI re-standardization committee felt that the original MMPI item pool was inadequate to cover several assessment issues that the committee deemed important. These included suicidal ideation, substance abuse problems, accessibility to psychotherapeutic treatment, problems in the work setting, and others. The committee, therefore, generated many new items in order to expand the number of items with content related to these areas. The occasion of the re-standardization afforded the committee members a rare and possibly unique opportunity to alter an item pool that had been fixed for nearly a half century. And given this opportunity, the members proceeded by a rational-deductive strategy, in which the formulation of new items was guided by the construct a desired future scale was intended to embody. But what of the assessor who is convinced of the merits of the rational strategy of scale construction but faced with an item pool that has been fixed, closed to new items and content? Harkness (1990) proposed that if new items could not be written in support of a construct that was not envisioned at the time the item pool became closed, the way was still open to rationally *select* items from the fixed pool to address new constructs. Specifically, Harkness proposed an approach he called *replicated rational selection*. Replicated rational selection is a rational-deductive strategy in that the scale development process begins with the specification of the construct to be

measured. It is at the next step that Harkness' strategy diverges from traditional methods. Instead of deducing new items to be written for the construct, items are selected from the established pool. The process remains deductive in that the selection of candidate items follows deductively from the construct to be measured. Whereas in the usual rational-deductive sequence, items may be written by any number of contributors, from one to many, it is the essence of Harkness' procedure that many selectors, a couple of dozen or more, having been trained in the defining features of the construct, in both its convergent and discriminant aspects, nominate items to be scaled: hence his designation of the procedure as *replicated* rational selection. Candidate items are then evaluated for the degree to which each attained consensus within the group of selectors. Thus, items arrange themselves along a selection gradient that displays a range from items selected only sporadically among the cadre of selectors to those whose frequency of nomination approaches unanimity. Items for which adequate consensus is found are then subjected to expert and statistical scrutiny to ensure overall semantic consistency and adequate internal consistency reliability. No items can be added at this stage, but a few may be deleted because of ambiguous wording or keying, compound phrasing, items with a primary focus on others rather than the self, or the retention of some items leads to an unacceptable decrement in internal consistency. Following this stage, the scale is ready for empirical trials to assess its construct validity.

The PSY-5 (Harkness, McNulty, & Ben-Porath, 1995) is a set of five scales that are intended to model the domain of disordered personality. These are Aggressiveness (*AGGR*), Psychoticism (*PSYC*), Disconstraint (*DISC*), Negative Emotionality/Neuroticism (*NEGE*), and Introversion/Low Positive Emotionality (*INTR*). (See the MMPI-2 *Manual*, Table B-6 for a listing of the item composition and scoring directions for the MMPI-2 PSY-5 scales; and Tables A-12 and A-13 for the uniform *T*-score conversions from raw scores for these scales.) Despite points of similarity with five factor models of normal personality derived from the broader lexicon of trait descriptive terms (The Big Five), Harkness and McNulty (1994) argued that measures based on such models, like the Neuroticism, Extraversion, and Openness Personality Inventory (NEO-PI), are less than optimal as applied to the routine tasks of clinical assessment and description, particularly with personality disordered patients.

The correspondence between the normal-sample-based Five Factor Model (FFM), as

represented by the scales of the NEO-PI-Revised (NEO-PI-R; Costa & McCrae, 1992b, 1992c, 1992d), and the PSY-5 is as shown in Table 7.6, in descending order of their similarity.

Relationships between the NEO-PI-R and PSY-5 are further described in Bagby, Sellbom, Costa, and Widiger (2008), Egger, De Mey, Derksen, and van der Staak (2003), and Trull, Useda, Costa, and McCrae (1995).

The extensive research literature on the PSY-5 scales is the subject of a recent comprehensive review by Harkness, Finn, McNulty, and Shields (2012) to which the reader is referred. In general, the research has affirmed the PSY-5 structural model as well as the psychometric properties, construct, and external validities of its component scales.

Arnau, Handel, and Archer (2005) sought to identify facet scales for the PSY-5 with a replicated principal components analysis (PCA) with tetrachoric correlations in majority outpatient samples of men and women ($Ns = \sim 4300$), with the number of retained components determined by parallel analysis. Thirteen facets were described, three each for *AGGR*, *PSYC*, and *INTR*, and two each for *DISC* and *NEGE*. However, Quilty and Bagby (2007), using both confirmatory and exploratory factor analysis (CFA/EFA) were unable to affirm the stability of these facet scales in a sample of men and women psychiatric patients ($N = 693$). Wang, Zhang, Shi, Zhou, and Li (2010), following a similar methodology, likewise found the Arnau et al. facet scales to have unacceptable reliabilities and validities in a Chinese sample. Based upon these findings, the Arnau et al. PSY-5 facet scales will not be described further below.

Effects of Response Styles on the PSY-5 Scales

Given their method of construction, the PSY-5 scales could not but have very high face validity. That is not to say, however, that their content will be obvious to the respondent. Whereas the items of *NEGE* and *PSYC* scores obviously refer to psychopathological disturbance, a great many if not the majority of the items on *DISC*, *AGGR*, and *INTR* scores refer to normal-range individual differences and are therefore less socially undesirable, on the whole, than *NEGE* and *PSYC*. To date, there have not been empirical

investigations of the effects of response sets on the PSY-5 scales in order to gauge their susceptibility to manipulation, but on the basis of the correlates of these scales, some effects can be anticipated. Sets to exaggerate distress or psychopathology will tend to elevate *NEGE*, *INTR*, and especially *PSYC*, whereas efforts to deny or conceal symptoms and maladjustment will tend to suppress these scales.

Like the MMPI-2 content scales, the great majority of the items on the PSY-5 scales are keyed True (the exception is *INTR*, for which about 85 percent of the items are keyed False). As a consequence, these scales are vulnerable to extremes in true-false responding. A high True percentage will sharply elevate *AGGR*, *NEGE*, and especially *PSYC*, while keeping *INTR* below *T*-50. A high False percentage will sharply elevate *INTR*, and confine scores on the other four scales to the average range or below.

AGGR (Aggressiveness)

- o focuses on offensive and instrumental aggression

T scores >65 are indicative of persons who:

- a) enjoy intimidating others and use aggression as a tool to accomplish goals
 - use offensive aggression
- b) interpersonally, high scores are linked to dominance and hate
- c) have a strong desire for power and influence
- d) are likely to be violent and cruel

Aggressiveness (AGGR)

Items: 18; 15 keyed *True*

Major Internal Correlates: Scales 9, *D-S* (low), *Ma4*, *ANG1*, *CYN2*, *ASP1*, *TPA2*, *RC9*, *R* (low), *GF* (low), *MAC-R*.

Description: *AGGR* is unique among MMPI/MMPI-2 scales in reflecting offensive or predatory aggression and the hostile urge to dominate, vanquish, and destroy others. About one-third of the items suggest assertiveness (Arnau,

Handel, & Archer, 2005), but most emphasize a theme of superiority and control avoidance, with additional subsets reflecting sadism and vindictiveness.

AGGR expressions of aggression, hostility, and control/domination are more apt to reflect cruelty than rage and are more apt to appear calculated, deliberate, methodical, and cold. By contrast, similar expressions from high scorers on *ANG*, *TPA*, and the like are more likely to be considered reactions to frustration or other provocation, and as rash, reckless, or ill-considered. *AGGR* suggests several paranoid dynamisms, including the defense mechanism, identification with the aggressor, the tendency to see interactions as moves in a zero-sum game and, possibly, the authoritarian complex of submissiveness with superiors and tyrannical relations with subordinates.

Interpretation: High scorers control others through the threat of their tempers. The self-concept is inflated, grandiose, and resentful, with a dread of being subject to another's control and a willingness to act sadistically and vindictively to avoid it. Relations with others are marked by aggressive efforts to control and dominate through fear and the threat of violence, and by resentment, hostility, and sadism.

Low Scores: Reflect the absence of a hostile orientation toward power, domination, and sadism characteristic of high *AGGR*. Scorers in the *T-45* to *T-55* range may manifest relatively high levels of social aggression by approaching and engaging others readily and without trepidation, but such aggression is free of hostile motive and a drive to dominate. Such scores may be compatible with the acceptance of relations with others on egalitarian terms, in which the mutual achievement of individual goals and fluctuations in hierarchical position (one-up; one-down) are considered to be natural and expected. Scores below *T-45* reflect subassertiveness in the context of dependency, passivity, submissiveness, and timidity (Weisenburger, Harkness, McNulty, Graham, & Ben-Porath, 2008).

Most Useful Comparisons: Scales *A* and *7*, *ANX*, *DEP*, *ANG*, *TPA*, *LSE*, *PSYC*, *DISC*, *NEGE*, *INTR*, and *RC9*. Elevations on the distress scales (*A*, *7*, *ANX*, *DEP*, *NEGE*), or the lack thereof, are useful in distinguishing between hostile outbursts instigated by stress and those that are the product of calculated vengeance or instrumental aggression. Perspective on the issue of calculated versus precipitate aggression may also be aided by referring to the relative elevations of *AGGR* and *ANG*. When *AGGR* is high and *A* and *INTR* are low, the control, domination, and harm that issues from the high *AGGR* scorer may be associated with pleasure, enjoyment, and a sense of well-being. Selfish and self-centered, yet

envious of others, the high *AGGR* scorer has a hostile narcissism that is heavily dependent on the attention and recognition of others. But the self-concept is so unrealistic, grandiose, and entitled that the desired reflections are forthcoming only under conditions of coercion. In this context, the combination of high *AGGR* with high *DISC* or high *PSYC* would appear to be especially dangerous.

In the case of high *AGGR* and high *DISC*, there is a synergy between sadistic motivation and deficits in behavioral control. Conjoint elevations on *AGGR* and *PSYC* suggest a risk for hostile action in the context of disordered thinking, such as bizarre and violent fantasy, command hallucinations, or ego-syntonic delusions, especially when *DISC* and *INTR* are high. In relation to low *AGGR* scores, low *DISC* suggests underassertion, passivity, and a high threshold for resisting domination. In this context, elevations on *NEGE* (or similar distress scales such as *A*, Scale 7, *ANX*, and *DEP*) may indicate patterns of behavior suggesting self-sabotage and self-defeat. Such a pattern is also consistent with symptoms of Obsessive-Compulsive Disorder. Low scores on *AGGR* with low *INTR* scores create a vulnerability to being played for a patsy by misplacing trust in others and approaching situations with a credulous confidence that most others would avoid.

Aggressiveness (AGGR) This PSY-5 scale assesses behaviors and attitudes characterized as an aggressive personality style. This scale assesses offensive and instrumental aggression rather than aggression that is reactive to behavior of others. High *AGGR* scorers might intimidate others and use aggression as a way of accomplishing their goals. They apparently have characteristics of dominance and hate. Studies have shown that both men and women with high *AGGR* scores were more likely to have a history of being physically abusive toward others (Graham et al., 1999). In this research, the investigators found that therapists rated the high-*AGGR* patients as having both aggressive and antisocial features. For example, high-*AGGR* men were more likely to have histories of domestic violence and high-*AGGR* women were found to be more likely to have been arrested than low-*AGGR* women.

Aggressiveness (AGGR)

The *AGGR* scale contains 18 items, 15 True, 3 False. More than a third of its items overlap with Wiggins' Manifest Hostility (*HOS*) and with Cook and Medley (1954) *Ho*. It is highly correlated with all of the scales within the aggressive tendencies cluster of the MMPI-2 content scales, ranging from a low of .45 for *ANG* to a high of .55 for *TPA*.

Other correlates include *R* (–.63); Scale 9 (.56); and the Narcissistic (*NAR*; .53), Histrionic (*HST*; .40), and Antisocial (*ANT*; .37) personality disorder scales of Morey et al. (1985). Sharpe and Desai (2001) found that *AGGR* correlated .60 with the Buss and Perry (1992) Aggression Questionnaire, and –.53 with the NEO-PI-R (Costa & McCrae [1992d]) Agreeableness, in a college sample (*N* = 234). *AGGR* is unique among MMPI/MMPI-2 scales in tapping offensive or predatory aggression. For example, it is considerably less saturated with nonspecific variance, correlating with Welsh’s *A* at –.01, than scales in the aggressive tendencies cluster whose correlations with *A* are in the .45 to .60 range. In this respect, *AGGR* is much “cooler” than any of the other anger/hostility scales for the MMPI/MMPI-2, including *ANG*, *TPA*, and *Ho*. The content of *AGGR* emphasizes a theme of superiority and control avoidance, with additional subsets reflecting sadism

Table 7.6 Correspondence of the PSY-5 to the Five-Factor Model (FFM)

FFM PSY-5

Neuroticism Negative Emotionality/Neuroticism

Extraversion Introversion/Low Positive Emotionality

(reversed)

Agreeableness Aggressiveness (reversed)

Conscientiousness Disconstraint (reversed)

Openness —

— Psychoticism and vindictiveness. *AGGR* expressions of aggression, hostility, and control/domination are more apt to reflect cruelty than rage and are more apt to appear calculated, deliberate, methodical, and cold. By contrast, similar expressions from, for example, high scorers on *ANG* and *TPA* are more likely to be seen as reactions to frustration or other provocation and as rash, unpremeditated, impulsive, and reckless or ill considered.

The *AGGR* scale reflects the hostile urge to antagonize, dominate, vanquish, and destroy others. Thus, it is predatory or sadistic aggression that is at stake in *AGGR* rather than the kind of (angry) aggression that is motivated by frustration in *ANG* and in *NEGE*. The self-concept is inflated, grandiose, and resentful, with a dread of being subject to the control of another and a willingness to act sadistically and vindictively in order to avoid such control. *AGGR* calls to mind several paranoid dynamisms, including the defense mechanism, identification with the aggressor, the tendency to see interactions as moves in a zero sum game and, possibly, the authoritarian complex of submissiveness with superiors and tyrannical relations with subordinates. The high *AGGR* scorer presents

as controlling others through the threat of his or her temper. Relations with others are marked by aggressive efforts to control and dominate through fear and the threat of violence and by resentment, hostility, and sadism. Wygant and Sellbom (2012) found a strong association between high *AGGR* scores and their global measure of psychopathy and its components.

Low *AGGR* scores will reflect less the absence of aggression, in the sense of approach, than of the hostile orientation toward power, domination, and sadism characteristic of high *AGGR* scores. Thus, the low *AGGR* scorer may manifest an aggressive, engaging style, but one that is less pressured and that accepts relations among others on horizontal, egalitarian terms, in which the mutual achievement of individual goals is not only conceivable but also expected. The low *AGGR* scorer accepts both one-up and one-down positions in his or her relations with others, knowing that these are transitory and subject to a variety of constraints that limit arbitrary vertical action of superior on subordinate. Weisenburger, Harkness, McNulty, Graham, and Ben-Porath (2008) reported that raw scores below seven for men and six for women were associated with therapist ratings of low aggressiveness and passive and submissive features in a sample of outpatients (N: M= 188; W = 287).

Relations to Other Scales

Assessment of the degree to which hostile expressions are likely to be calculated versus precipitate may be aided by reference to the relative elevations of *AGGR* and *ANG*.

AGGR shares some common variance with three other PSY-5 scales, Disconstraint (*DISC*; .42), and Introversion/Low Positive Emotionality (*INTR*; -.29), conceived as anergy, low activation, or low readiness to act, and Psychoticism (*PSYC*; .33), reflecting an unrealistic view of self and others and one that overemphasizes issues of power and control. The shared variance between *AGGR* and *INTR*, along with the absence of variance in common with *A*, suggests that the control, domination, and harm that issues from the high *AGGR* scorer is associated with pleasure, enjoyment, and a sense of wellbeing. Selfish, self-centered, and yet envious of others, the high *AGGR* scorer reflects a hostile narcissism that is heavily dependent on the attention and recognition of others. But the self-concept is so unrealistic, grandiose, and entitled that the desired reflections

are forthcoming only under conditions of coercion. In this context, the combination of high *AGGR* scores with high *DISC* scores or with high *PSYC* scores would appear to be especially dangerous combinations. In the case of high *AGGR* and high *DISC* scores, there is a synergy between sadistic motivation and deficits in behavioral control. Conjoint elevations on *AGGR* and *PSYC* suggest a risk for hostile action in the context of disordered thinking, such as bizarre and violent fantasy, command hallucinations or ego-syntonic delusions, especially when *DISC* and *INTR* are high.

The *AGGR* scale has an obvious bearing on the quality and dynamics of treatment relationships, especially when *DISC* scores are high and *NEGE* scores are at least moderately high, with high scorers likely to violate treatment plans, fail to follow through on agreements, discontinue medication, and in other ways undermine therapeutic efforts.

In relation to low *AGGR* scores, low *DISC* scores suggest under-assertion, passivity, and a high threshold for resisting domination. In this context, elevations on *NEGE* (or similar distress scales, such as *A*, Scale 7, *ANX*, and *DEP*) may indicate patterns of behavior suggesting self-sabotage and self-defeat. Such a pattern would also be consistent with symptoms of obsessive–compulsive disorder. Low *AGGR* scores with low *INTR* scores would seem to create a vulnerability to being played for a patsy by misplacing trust in others and approaching situations with a kind of credulous confidence that most others would avoid.

PSYC (Psychoticism)

- assesses disconnection from reality
 - a) unshared beliefs, as well as unusual sensory and perceptual experiences

- Alienation and unrealistic expectation of harm are also assessed

T scores >65 are indicative of persons who:

- a) have a higher probability of delusions of reference
- b) have thinking that is disorganized, bizarre, disoriented, circumstantial or tangential
- c) “think away from reality,” have perceptual aberrations, and espouse magical ideation

PSY-5: Psychoticism (PSYC)

Items: 25; 23 keyed *True*

Major Internal Correlates: Scales A, F, 6, 7, and 8, *Pd-O*, *Pa1*, *Pa-O*, *Sc1*, *Sc5*, *Sc6*, *Si3*, *Ma-O*, *BIZ1*, *BIZ2*, *CYN2*, *RC6*, *RC8*, and negatively with *S*.

Description: Highly similar to *BIZ*, with which it shares 14 items and correlates at .94, but having a slightly greater and somewhat broader paranoid edge, the two largest groupings of items have active psychotic and active persecutory content, respectively. Additional subsets of items concern unusual experience/magical ideation, daydreaming, withdrawal, mistrust, and suspiciousness. *PSYC* overlaps *RC6* by 10 items and *RC8* by 8 items (versus 10 and 12 items, respectively, for the latter two scales with *BIZ*).

Interpretation: At moderate elevations (55T–65T), *PSYC* reflects mostly unusual beliefs or experiences and a tendency to overindulge in daydreaming. Any elevation may be taken as a sign of reluctance to engage the world and other people in conventional terms. Even at mild and moderate elevations, *PSYC* reflects disharmony in one’s relations with the physical and social worlds such that functioning is compromised and relationships are alienated. At these levels, the person may give the appearance of being in the world but not of it. At higher elevations one encounters severe distortions in the way the individual interacts with his or her social and physical worlds, such that these interactions appear, respectively, hostile, provocative, offensive, or inept; and incompetent, irrelevant, bizarre, or self-defeating. At elevations greater than T-65, however, suspiciousness and true psychotic phenomena make an appearance, including Schneiderian symptoms and fixed persecutory if not frankly delusional ideation. In general, the high *PSYC* scorer presents as odd in appearance, behavior, and belief. He or she appears to be preoccupied with fantasy and daydreaming and seems out of touch with reality. Relations with others are apt to be minimal, distant, and covertly hostile, with a readiness to feel mistreated and resentful.

Low Scores: These are largely without symptomatic significance apart from the absence of those features associated with high scores.

Most Useful Comparisons: Scales *A*, *F*, *6*, *7*, and *8*, *Pd4*, *Pd-O*, *Pa1*, *Pa-O*, *Sc1*, *Sc5*, *Sc6*, *ANX*, *BIZ1*, *BIZ2*, *CYN2*, *AGGR*, *DISC*, *NEGE*, *RC6*, *RC8*. Because the content of about 40% of *PSYC* items is persecutory or suspicious in character, reference can be made to *Pa1* and *RC6* to estimate the contribution of paranoid ideation to *PSYC* elevations. Elevations on *A*, *7*, *ANX*, and *NEGE* suggest distress associated with psychoticism, or the lack of such distress when these scales are low. Scales *Pd4*, *Pd-O*, and *Sc1* and scales *Sc5*, *AGGR*, and *DISC* reflect accompanying levels of alienation and hostile dyscontrol, respectively.

The *PSYC* scale addresses whether the client experiences a mental disconnection from reality. The content on the scale contains items that address unusual sensory and perceptual experiences, delusional beliefs, and other peculiar behaviors or attitudes. Persons who score high also acknowledge experiencing alienation from others and unrealistic expectation of harm from other people. They tend to have a greater likelihood of experiencing psychotic behavior such as delusions of reference, disorganized thinking, bizarre behavior, and disoriented, circumstantial, or tangential thought processes. Those being seen on an inpatient basis are found to be more likely to manifest psychotic-like behavior such as paranoid suspiciousness, ideas of reference, loosening of associations, hallucination, or flight of ideas. Outpatients, as noted by Graham et al. (1999), had low rates of frank psychosis; however, those with elevated *PSYC*-scale scores were reported to have generally lower functioning and to have few or no friends. They were also found to be depressed on mental status examination. In this study, therapists rated high-*PSYC* patients as low in achievement orientation. High-*PSYC* men were described as being depressed by their therapists. High-*PSYC* women showed a tendency to report more hallucinations at intake in inpatient settings than women with low scores.

Psychoticism (PSYC)

The *PSYC* scale contains 25 items, 23 True, 2 False. *PSYC* is strongly correlated with measures of similar constructs, including *BIZ* (.94), with which it shares 14 items, *F* (.71), and Scales 8 (.69) and 6 (.65). Additional correlates include *OBS* (.66) and *CYN* (.64), and Morey, Waugh, and Blashfield's (1985) Paranoid Personality Disorder (*PAR*, .64). The two largest groupings of items have active psychotic experience, including delusions of control, and active persecutory content, respectively. Additional subsets of items concern unusual experience/magical ideation, daydreaming, and suspiciousness.

Harkness, McNulty, and Ben-Porath (1995) describe *PSYC* as assessing "the gross verisimilitude of [one's] inner models of the outer social and object world" (p. 105).

Thus, it is intended to reflect the extent to which the individual's ability to conform his or her thinking to consensual views of the external world and to the human action within it—and to correct elements of thinking and interpretation that render one's model of reality a poor fit to the actual external situation—is impaired. At moderate elevations

(*T*-55–65), *PSYC* may reflect little more than unusual beliefs or experiences, and perhaps a tendency to overindulge in daydreaming. Any elevation may be taken as a sign of reluctance to engage the world and other people in conventional terms. Even at mild and moderate elevations, *PSYC* reflects disharmony in one's relations with the physical and social worlds such that functioning is compromised and relationships are alienated. At these levels, the person may give the appearance of being "in the world but not of it." At higher elevations one encounters severe distortions in the way the individual interacts with his or her social and physical worlds, such that these interactions appear, respectively, hostile, provocative, offensive, inept or incompetent, irrelevant, bizarre, or self-defeating. At elevations greater than *T*-65, however, true psychotic phenomena make an appearance, including Schneiderian symptoms, fixed persecutory if not frank delusional ideation, and suspiciousness. In general, the high *PSYC* scorer presents as odd, peculiar, or weird in appearance, behavior, and belief. He or she appears to be preoccupied with fantasy and daydreaming and seems alienated and "out of touch with reality." Relations with others are apt to be minimal, distant, and covertly hostile, with a readiness to feel mistreated and resentful.

Low *PSYC* scores are largely without symptomatic significance apart from the absence of those features associated with high scores. However, in terms of its guiding construct, one would expect low *PSYC* scores to carry favorable implications regarding the individual's ability to detect and correct misimpressions in order to accommodate previous editions of his or her inner model of reality to newly apprehended features of the human and nonhuman environment.

Relations to Other Scales

Because the content of about 40 percent of the *PSYC* items is persecutory or suspicious in character, reference can be made to the *PaI* subscale (Ideas of External Influence) to estimate the contribution of paranoid ideation to *PSYC* elevations.

DISC (Disconstraint)

T scores >65 are indicative of persons who:

- a) are risk taking, impulsive and less traditional
- b) have a tendency to prefer romantic partners who have the same features
- c) tend to be easily bored with routine
- d) have an increased level of rule breaking and higher levels of criminality
- e) tend to ignore moral codes

T scores <40 are indicative of persons who:

- a) are risk-averse, have high levels of personal control, hold traditional moral views, have an increased level of rule following, and low levels of criminality

PSY-5: Disconstraint (DISC)

Items: 28; 17 keyed *True*

Major Internal Correlates: Scales 9, *D-S*, *Pd2*, *Ma1*, *ASP1*, *ASP2*, *AGGR*, *RC4*, *MAC-R*, *AAS*, and negatively with *R*, *Re*, and *GF*.

Description: A broad dimension of behavioral undercontrol. The largest subset of items reflects an expedient, anything-goes morality. Items of a somewhat smaller group, all of which are contained in *ASP2*, admit delinquent conduct. Four additional groups of items concern sensation seeking, impulsivity, sexual disinhibition, and fearlessness (two items). The main theme is undermodulation of impulse, spontaneity, broad interests, cognitive and moral flexibility, insufficient delay of gratification, and an independence from familiar rubrics. Scores are suppressed by age.

Interpretation: High scores reflect an unconventional, disinhibited personality structure with insufficient delay and modulation of impulse, a nonconforming and rebellious attitude toward rules and regulations, sensation seeking, shallow and self-centered loyalties, a hedonistic moral compass, indifference to or disdain for legal and ethical constraints, a fearless or reckless disregard for potential physical hazards, and a tendency to sacrifice long-term goals for short-term satisfactions. The high *DISC* scorer may present initially as energetic and spontaneous, but upon closer acquaintance comes to appear unreliable, reckless, and rebellious. Relations with parents and authority figures tend to be conflicted; relations with peers and others tend to be exploitive, promiscuous, and unstable.

Impulsive and antisocial acting out, a lack of loyalty, repeated lying and neglect seems out of touch with reality. Relations with others are apt to be minimal, distant, and covertly hostile, with a readiness to feel mistreated and resentful.

Low Scores: These are largely without symptomatic significance apart from the absence of those features associated with high scores.

Most Useful Comparisons: Scales *A*, *F*, *6*, *7*, and *8*, *Pd4*, *Pd-O*, *Pa1*, *Pa-O*, *Sc1*, *Sc5*, *Sc6*, *ANX*, *BIZ1*, *BIZ2*, *CYN2*, *AGGR*, *DISC*, *NEGE*, *RC6*, *RC8*. Because the content of about 40% of *PSYC* items is persecutory or suspicious in character, reference can be made to *Pa1* and *RC6* to estimate the contribution of paranoid ideation to *PSYC* elevations. Elevations on *A*, *7*, *ANX*, and *NEGE* suggest distress associated with psychoticism, or the lack of such distress when these scales are low. Scales *Pd4*, *Pd-O*, and *Sc1* and scales *Sc5*, *AGGR*, and *DISC* reflect accompanying levels of alienation and hostile dyscontrol, respectively. of obligations, and a lack of shame or remorse eventually may disrupt all but correctional relationships. Look for substance abuse.

Low Scores: The low *DISC* scorer presents as conventional, conforming, and controlled. Relations with others may be smooth but distant, formalized, and routinized, with contacts limited to a small circle of like-minded friends. A high tolerance for boredom, sameness, and routine and a relatively rigid adherence to traditional moral standards, along with a willingness to judge others in terms of these standards, are characteristic. Very concerned with maintaining appearances, the low *DISC* scorer takes an overly deliberate if not perfectionistic approach to problem solving. Obsessive-compulsive trends may be present.

Most Useful Comparisons: Scales *4* and *9*, *Pd2*, *Pa1*, *Sc5*, *Ma1*, *Ma2*, *Ma3*, *Ma4*, *BIZ1*, *BIZ2*, *ANG1*, *ASP1*, *ASP2*, *AGGR*, *PSYC*, *RC4*, *R* (low), *Re* (low), *MAC-R*, *AAS*. It is often helpful to determine whether behavioral undercontrol may have a psychotic basis, such as mania.

Disconstraint (DISC) This scale was developed to provide an assessment of a client's potential to act impulsively. This pattern of impulsive behavior can involve three aspects: (a) accepting a higher level of physical risk-taking, (b) possessing a style characterized more by impulsivity than control, and (c) being less confined by traditional moral constraints. According to Harkness and colleagues, this dimension is closely related to Zuckerman's high-scoring "Sensation Seekers" (Zuckerman et al., 1972). People who score high on *DISC* have difficulty learning from past behavior or punishing experiences and tend to

repeat their acting out over time.

High scorers on DISC tend to be high risk-takers; they are impulsive and nonconforming in their approach to life. They tend to become easily bored and do not like routine activities. In the Graham et al. outpatient sample (1999) outpatients who scored high on DISC had a history of being arrested and reported extensive alcohol, cocaine, and marijuana abuse. High DISC scorers were rated by therapists in the study by Graham et al. as both aggressive and antisocial. The outpatient high-DISC men had histories of perpetrating domestic violence.

Disconstraint (DISC)

The *DISC* scale contains 28 items, 17 True, 11 False. It is moderately correlated with *ASP* (.57), with which it shares eight items, and with the Morey et al. (1985) Antisocial Personality Disorder scale (*ANT*; .50). It overlaps negatively nine items with *GF* and seven items with *Re. DISC* is the only one of the PSY-5 scales for which age appears to be an important moderator, with scores tending to decrease with age ($r = -.24$; Harkness, Spiro, Butcher, & Ben-Porath, 1995). The largest subset of items reflects an expedient morality such that “anything goes.” A somewhat smaller group of items reflects stimulation seeking. Four additional groups of items concern delinquent conduct, sexual disinhibition, activity, and the denial of heights and fire (two items). The main theme is one of under-modulation of impulse, spontaneity, broad interests, cognitive and moral flexibility, insufficient delay of gratification, and an independence from familiar if not hackneyed rubrics. High scores reflect an unconventional, intrepid, disinhibited personality structure with insufficient delay and modulation of impulse, a nonconforming and rebellious attitude toward rules and regulations, sensation seeking, shallow and self-centered loyalties, a hedonistic moral compass, indifference to, if not disdain for, legal and ethical constraints, a fearless if not reckless disregard for potential physical hazards, and a tendency to sacrifice long-term goals for short-term satisfactions. The high *DISC* scorer may present initially as energetic and spontaneous, but on closer acquaintance comes to appear unreliable, reckless, and rebellious. Relations with parents and authority figures tend to be conflicted; relations with peers and others tend to be exploitive, promiscuous, and unstable. Impulsive and antisocial acting out, a lack of loyalty, repeated lying and neglect of obligations, and a lack of shame or remorse eventually may disrupt all but correctional relationships. Wygant and Sellbom

(2012) reported an association between high *DISC* scores and the behavioral features of psychopathy.

The low *DISC* scorer, by contrast, presents as conventional, conforming, and controlled. Relations with others may be quite smooth but distant, formalized, and routinized, with contacts limited to a small circle of like-minded friends. A high tolerance for boredom, sameness, and routine and a relatively rigid adherence to traditional moral standards, along with a willingness to judge others in terms of these standards, are characteristic. Very concerned with maintaining “proper” appearances, the low *DISC* scorer takes an overly deliberate if not perfectionistic, approach to problem solving.

Relations to Other Scales

DISC appears to occupy the position formerly held by Block’s (1965) Ego Control (*EC-5*, scoring reversed) in the MMPI environment. The re-standardization entailed the loss of nearly a third of the *EC-5* items, with uncertain consequences for its adequacy as a marker for the second (or beta) factor of the MMPI/MMPI-2. With its emphasis on emotional inhibition, social withdrawal, and narrow interests, Repression (*R*) has been the traditional marker for this factor. An alternative marker for the same factor, *EC-5* emphasized behavioral over emotional constraint, with particular reference to rule following and social conformity. The Harkness, McNulty, and Ben-Porath (1995) Disconstraint construct is very similar to *EC-5* (reversed) and shares a similar level of association with *R*, about $-.40$. Because, like distress, emotional and behavioral controls are of pervasive significance in psychopathology, both *R* and *DISC* may contribute to the interpretation of most other scales. Discussion of *DISC* in relation to other scales is therefore highly selective.

In their discussion of *DISC*, Harkness, McNulty, and Ben-Porath (1995) called attention to the similarity between it and the personality disorder simplex found by Romney and Bynner (1992): both had antisocial personality at one end and compulsive personality at the other. Although it is unknown whether and to what extent *DISC* scores (when low) are sensitive to obsessive–compulsive personality disorder, for reasons having to do with the pervasiveness of the constraint dimension across a variety of

psychiatric conditions, scores on this scale may well contribute to the discrimination between obsessive–compulsive disorder and obsessive–compulsive personality disorder. Along with investigation of the correlates of both high and low *DISC* scores in relevant psychiatric samples, it may also be illuminating to examine configurational relationships of *OBS* with *DISC*. For example, are small (or negative) *OBS-DISC* differences associated with obsessive–compulsive personality disorder but not with obsessive–compulsive disorder, as might be expected, whereas larger differences in the context of high *OBS* scores (and, perhaps, a relatively large *FRS-DISC* difference) show the opposite pattern? With high *DISC* scores and moderate to high *NEGE* scores, one could anticipate contranormative approaches to coping with subjective discomfort, such as through alcoholism or other substance abuse. Harkness, Levenson et al. (1995) in a study of the Boston VA normative aging sample found that the *DISC* (formerly *COM*) and *NEGE* scales were the top-ranked variables contributing to the separation of problem and heavy drinkers from non-problem drinkers. High *DISC* scores would synergize with low *INTR* scores to produce adventurousness, sensation seeking, and sometimes recklessness. In the context of low *NEGE* scores and high *AGGR* scores, this pattern would suggest the classic amoral/asocial psychopathic picture. Low *DISC* and high *NEGE* scores would appear to coincide with immaturity and a lack of responsibility and to reflect those problems of impulse control in which impulsive action is reinforced by tension reduction. High *DISC* and high *PSYC* scores may synergize to emphasize a readiness to indulge in fantasy (including bizarre fantasy) and daydreaming, especially when *INTR* scores are high. Egger, Delsing, and DeMey (2003) found that *DISC* scores were significantly higher in their Bipolar 1 patients than in their psychotics.

NEGE (Negative Emotionality/Neuroticism)

T scores >65 are indicative of persons who:

- a) focus on problematic aspects of information
- b) worry
- c) are self-critical
- d) feel guilty
- e) feel nervous
- f) create worst-case scenarios
- g) experience negative affect and emotion

PSY-5: Negative Emotionality/Neuroticism (NEGE)

Items: 33; 27 keyed *True*

Major Internal Correlates: Scales *A*, *7*, and *8*, *D5*, *Pd-O*, *Si3*, *ANX*, *FRS*, *OBS*, *DEP*, *ANG2*, *WRK*, *TRT*, *RCd*, *RC7*, and negatively with *K*, *S*, and *Es*.

Description: A broad dimension similar to the First Factor of the MMPI-2 and highly correlated with *A* (.89), *RC7* (.87), and *RCd* (.79). The largest subset of items reflects worry, nervousness, anxiety, tension, and stress. Nine of these items overlap *ANX*; seven overlap *RC7*. A second subset reflects anger, irritability, and emotional undercontrol. Six of these items overlap *ANG*, three each on *ANG1* and *ANG2*. Two smaller groups of items denote fears (four items on *FRS*, three on *FRS1*) and guilt, respectively. *NEGE* reflects the sense of being so overwhelmed with the stress of worry, nervousness, fear, and guilt that one feels at the end of one's rope and quick to anger. Two themes are implicit in the item content: (a) a pervasively unpleasant and aversive emotional life, one that feels both relentless and intrusive, leading to (b) inner agitation and a feeling that one's controls have been taxed by this relentlessly aversive emotionality to the point of collapse.

Interpretation: High scorers present as helpless, dependent, needy, indecisive, and unstable. Relations with others are characterized by extreme passivity, fears of abandonment, and hypersensitivity to criticism. They may provoke exasperation

in others as they continually fail to take initiative to improve their situation and to act in their own best interest. Borderline attachments to others, help-rejecting complainingness, and suicidal or self-mutilative behavior may be seen.

Low Scores: Reflect a relaxed and imperturbable emotionality that may be so care- and worry-free as to suggest an impoverishment of internal experience and awareness, and raise the question of repressiveness. At the extreme, low scores reflect a placid emotional life that may be impervious to disruption.

Most Useful Comparisons: Scales 7 and 8, *A*, *ANX*, *FRS*, *OBS*, *DEP*, *HEA*, *BIZ*, *ANG*, *AGGR*, *PSYC*, *DISC*, *RC7*. It is helpful to compare the elevation on *NEGE* with that of *PSYC*, as this provides the best and most convenient quick measure of the profile's neurotic-psychotic balance.

Negative Emotionality/Neuroticism (NEGE) The *NEGE* scale addresses the high degree of negative feeling and dysphoria that many people in mental health settings experience. High scorers tend to focus on problems rather than positive events in their lives. They tend to worry to excess over minor events and tend to be highly self-critical. They usually evaluate possible outcomes as negative when faced with uncertainty. Graham et al. (1999) reported that outpatients in their study were more likely to be given diagnoses with depression or dysthymic disorder. Therapists rated them as generally low functioning. High scorers also tended to complain a lot about physical problems.

Negative Emotionality/Neuroticism (NEGE)

The *NEGE* scale contains 33 items, 27 True, 6 False. It is highly correlated with markers for the first factor, including *A* (.87) and Scale 7 (.84), as well as with *ANX*, *WRK*, *OBS*, and, importantly, *ANG*. Its overlap with *A*, however, is confined to only six items. The largest subset of items reflects worry, nervousness, anxiety, tension, and stress. A second subset reflects anger and emotional loss of control; six items overlap with *ANG*, three each on *ANG1* and *ANG2*. Two smaller groups of items denote guilt and fears, respectively. *NEGE* reflects the sense of being so overwhelmed with the stress of worry, nervousness, fear, and guilt that one feels “at the end of one’s rope” and “quick to fly off the handle.” Two themes are implicit in the item content: (a) a pervasively unpleasant and aversive emotional life, one that feels both relentless and intrusive, leading to

inner agitation, and (b) a feeling that one's controls have been taxed by this relentlessly aversive emotionality to the point of collapse. The high *NEGE* scorer presents as helpless, dependent, needy, indecisive, and unstable. Relations with others are characterized by extreme passivity, fears of abandonment, and hypersensitivity to criticism. He or she may provoke exasperation in others as there may be repeated failures to take initiative to improve the situation and to act in his or her best interest. Borderline attachments to others, help-rejecting complaining-ness, and suicidal or self-mutilative behavior may be seen.

At the low end, *NEGE* reflects a relaxed and imperturbable emotionality that is so care- and worry-free as to suggest an impoverishment of internal experience and awareness, thus raising the question of repressiveness. In any case, at the extreme, low scores are likely to reflect an emotional life that is placid to the point of imperviousness. Wygant and Sellbom (2012) found an association between low *NEGE* scores and the low affectivity of the psychopathy construct.

Relations to Other Scales

As one more congener of the first factor, *NEGE* is related to distress across a wide range of manifestations.

INTR (Introversion/Low Positive Emotionality)

T scores >65 are indicative of persons who:

- a) experience little joy or positive engagement

T scores of <40 are indicative of persons who:

- a) experience positive affect
- b) seek out and enjoy social experiences
- c) have the energy to pursue goals and be engaged in life's tasks

PSY-5: Introversion/Low Positive Emotionality (INTR)

Items: 34; 5 keyed *True*

Major Internal Correlates: Scales 2, 7, and 0, *D1, D2, D4, D5, D-O, Hy3, Hy-O, Sc2, Sc4, Si1, Si2, DEP1, DEP2, LSE1, SOD1, SOD2, WRK, TRT1*.

Description: Items reflect social disengagement and a lack of emotional buoyancy. The largest subsets of items claim low energy and hedonic capacity, and social awkwardness/discomfort and withdrawal. Three smaller groups of items deny personal adequacy, persistence, and euphoria. An analogue of the 2-0/0-2 codetype (overlaps Scale 2 by 12 items [11 on *D1*], and *RC2* and Scale 0 by 9 items [5 on *Si2*]).

Interpretation: Characteristic features include anhedonia, anergy, dissatisfaction, low self-esteem, and a tendency to give up quickly in the face of difficulty. High scores suggest an impoverished emotional life more than the presence of unpleasant or aversive emotionality, as in the case of *NEGE*. They may also reflect depressive withdrawal, schizoid underinvolvement, or both, depending on the particular pattern of items endorsed. The high *INTR* scorer is uncomfortable around other people and tends to avoid social situations. Relations with others are distant though not hostile. Rather, high *INTR* scorers tend to react to others impassively when interaction cannot be avoided.

Low Scores: Present as sociable, outgoing, visible, warm, and socially attractive or charismatic. Relations with others are friendly and easygoing, based on high self-esteem, freedom from debilitating stresses, distinct pleasure in interaction with others, and mutual respect for their rights and freedoms. The low scorer describes high self-esteem; feeling liked and accepted by others; a quickness to feel pleasure and fulfillment; a deep reservoir of energy for pursuing goals; and a sense of happy connection with others that includes a desire for close and intimate relationships. Very low scores may reflect hypomania.

Most Useful Comparisons: Scales 2 and 0, *D1, D-O, Si1, Si2, SOD1, SOD2, AGGR, DISC*. *DISC* may be an important modifier of *INTR* scores, with low scores on both scales suggesting that the social buoyancy of *INTR* is controlled and socially constructive. When *DISC* is high and *INTR* is low, the person's sociability is apt to be superficial and utilitarian. This combination suggests an especially high

rate of social turnover, as the need for stimulation and novelty undermines loyalty and results in a lowered threshold for boredom in relationships. Conversely, low *DISC* in the context of high *INTR* reflects not only drastically curtailed social initiative but also a high tolerance for predictability and sameness in relations with others. This is a formula for relationships that, however long-lived, remain shallow. With moderately high *AGGR*, the low *INTR* scorer may be more dominant and controlling and have significant problems with compromise.

Introversion/Low Positive Emotionality (INTR) The PSY-5 *INTR* scale addresses the capacity of the client to experience feeling good and to work effectively with others. High scorers show little capacity to experience pleasure and are viewed as low in positive relations with others. They report a low ability to enjoy life, referred to as being low in “hedonic capacity.” Both high-scoring men and women report being introverted and depressed. In the study by Graham et al. (1999), high *INTR* scorers were seen as depressed and sad in their interviews. They tended also to have low achievement motivation and were seen as overly anxious, depressed, introverted, and pessimistic by their therapists. They complained of numerous somatic symptoms.

Introversion/Low Positive Emotionality (INTR)

The *INTR* scale contains 34 items, 5 True, 29 False. Correlates with other MMPI-2 scales include Scales 2 (.79) and 0 (.76)—it shares 13 items with each—and with *DEP* (.61) and *SOD* (.73). Among the Morey et al. (1985) personality disorder scales, *INTR* has positive correlations with Avoidant (*AVD*; .68), Schizotypal (*STY*; .61) and Schizoid (*SZD*; .52), and negative correlations with Narcissistic (*NAR*; −.71) and Histrionic (*HST*; −.64). The largest subsets of items claim dysphoria, low energy and hedonic capacity, and social avoidance/withdrawal. Three smaller groups of items deny personal adequacy, persistence, and euphoria. *INTR* reflects social disengagement and a lack of emotional buoyancy. High scores suggest not so much the presence of unpleasant or aversive emotionality, as in the case of *NEGE*, as of a depleted, impoverished, emotional life. Characteristic features include anhedonia, anergy, dissatisfaction, low self-esteem, and a tendency to give up quickly in the face of difficulty. Depending on the particular pattern of items endorsed, high *INTR* scores may reflect depressive withdrawal, schizoid underinvolvement, or both. The high *INTR* scorer is uncomfortable around other people and

tends to avoid social situations. Relations with others are distant, although not hostile; rather, the high *INTR* scorer tends to react to others in an impassive way when interaction cannot be avoided. A defective pleasure parameter (Meehl's 1974, 1987, anhedonia) may be at the root of the high *INTR* scorer's impoverished emotional responsiveness.

The low *INTR* scorer presents as sociable, outgoing, visible, warm, engaged, and socially attractive if not charismatic. Relations with others are warm and easygoing, based on high self-esteem, freedom from debilitating stresses, distinct pleasure in interaction with others, and mutual respect for their rights and freedoms. The low *INTR* scorer describes high self-esteem, feeling liked and accepted by others, a quickness to feel pleasure and fulfillment, a deep reservoir of energy for the pursuit of goals, and a sense of happy connection with others that includes a desire for close and intimate relationships.

Relations to Other Scales

DISC may be an important modifier of *INTR* scores, with low scores on both scales suggesting that the social buoyancy of the low *INTR* score is controlled and socially constructive. When *DISC* scores are high and *INTR* scores are low, the person's sociability is apt to be superficial and utilitarian. This combination suggests an especially high rate of social turnover, as the need for stimulation and novelty undermines loyalty and results in a lowered threshold for boredom in relationships. Conversely, low *DISC* scores in the context of high *INTR* scores reflect not only drastically curtailed social initiative, but also a high tolerance for predictability and sameness in relations with others. This is a formula for relationships that, however long-lived, may remain shallow. With moderately high *AGGR* scores, the low *INTR* scorer may be more dominant and controlling and have significant problems with joining others in compromise.

Subtle & Obvious subscales

a. Weiner & Harmon, 1948

b. looked at faking good and faking bad protocols

1. in terms of subtle vs. obvious questions on Scales 2, 4, 4, 6, & 9

c. subtle items:

1. those clinical scale items that do not seem to relate to the construct that is the focus of measurement

d. obvious items:

1. those clinical scale items that do seem to be related to the construct being measured

e. created for D, Hy, Pd, Pa, and Ma scales

f. others argue that the standard validity scales work better to determine faking good and faking bad

Harris-Lingoes Scales

1) Harris & Lingoes, 1955

2) created from the clinical scales

- a. since clinical scales were created empirically, there is a lot of item heterogeneity
- b. H-L scales were created based on the content of the items
- c. are the most comprehensive of the content-type scales derived for the MMPI

3) used for scales 2, 3, 4, 6, 8, 9

4) most useful when elevated scores

- a. do not seem to match the overall profile
- b. when scales are marginally elevated

5) typically, do not interpret if there are no elevated clinical scales

The five Harris-Lingoes subscales for Scale 2 are extensively overlapping. Of the 49 items that appear on one of the subscales, 23 appear on two or more, for a total of 55 overlaps. *D1*, for example, overlaps with *D2* (8 items), *D3* (3 items),

and *D4* (12 items), and contains all 10 of the *D5* items. Five *D2* items overlap with *D4* and two with *D5*; *D4* and *D5* overlap by four items.

The Harris–Lingoes Subscales

The Harris–Lingoes subscales are item subsets that were developed for six of the MMPI empirical scales by rational analysis. Harris and Lingoes (1955) constructed their item subgroups by reading through the items on the D, Hy, Pd, Pa, Sc, and Ma scales and rationally grouping the items according to content themes. The authors did not provide subscales for scales 1 (Hs) and 7 (Pt) because these scales were believed to be “naturally” homogeneous in content and not subject to further reduction into subthemes. The Hs scale contains strictly somatic problems, and the Pt scale comprises anxiety indicators. A listing of the Harris–Lingoes subscales is given in Table 5.2.

Table 5.2 Description of the Harris–Lingoes Subscales for the MMPI-2

Scale 1 Hypochondriasis: None

Scale 2 Depression

D1—Subjective Depression 32 items

High scores suggest: feeling depressed, unhappy, nervous; lacks energy and interest; not coping well; problems in concentration and attention; feels inferior; lacks self-confidence; shy and uneasy in social situations feels inferior; lacks self-confidence

D2—Psychomotor Retardation 14 items

High scores suggest: immobilized, withdrawn; lacks energy; avoids people; denies hostility

D3—Physical Malfunctioning 11 items

High scores suggest: preoccupied with physical functioning; denies good health; wide variety of somatic complaints

D4—Mental Dullness 15 items

High scores suggest: lacks energy; feels tense; has problems in concentration and attention; lacks self-confidence; feels life is not worthwhile

D5—Brooding 10 items

High scores suggest: broods, ruminates; lacks energy; feels inferior; feels life is not worth living; easily hurt by criticism; feels like losing control of thought process

Scale 3 Hysteria

Hy1—Denial of Social Anxiety 6 items

High scores suggest: socially extroverted and comfortable; not easily influenced by social standards and customs

Hy2—Need for Affection 12 items

High scores suggest: strong needs for attention and affection; sensitive, optimistic,

trusting; avoids confrontations; denies negative feelings toward others

Hy3—Lassitude, Malaise 15 items

High scores suggest: uncomfortable and not in good health; tired, weak, fatigue; problems in concentration; poor appetite; sleep disturbance; unhappy

Hy4—Somatic Complaints 17 items

High scores suggest: multiple somatic complaints; utilizes repression and conversion of affect; little or no hostility expressed

Hy5—Inhibition of Aggression 7 items

High scores suggest: denies hostile and aggressive impulses; sensitive about response of others

Scale 4 Psychopathic Deviate

Pd1—Familial Discord 9 items

High scores suggest: views home situation as unpleasant and lacking in love, support, understanding; family critical and controlling

Pd2—Authority Problems 8 items

High scores suggest: resents authority; trouble in school and with law; definite opinions about right and wrong; stands up for beliefs

Pd3—Social Imperturbability 6 items

High scores suggest: comfortable and confident in social situations; exhibitionistic; defends opinions

Pd4—Social Alienation 13 items

High scores suggest: feels misunderstood, alienated, isolated, estranged; lonely, unhappy, uninvolved; blames others; self-centered, inconsiderate; verbalizes regret and remorse

Pd5—Self-Alienation 12 items

High scores suggest: uncomfortable, unhappy; problems in concentration; life not interesting or rewarding; hard to settle down; excessive use of alcohol

Scale 6 Paranoia

Pa1—Persecutory Ideas 17 items

High scores suggest: views world as threatening; feels misunderstood, unfairly blamed or punished; suspicious, untrusting; blames others; sometimes delusions of persecution

Pa2—Poignancy 9 items

High scores suggest: sees self as high-strung, sensitive, feeling more intensely than others; feels lonely, misunderstood; looks for risk and excitement

Pa3—Naïveté 9 items

High scores suggest: extremely naïve and optimistic attitudes toward others; trusting; high moral standards; denies hostility

Scale 7 Psychasthenia: None

Scale 8 Schizophrenia

Sc1—Social Alienation 21 items

High scores suggest: feels misunderstood, mistreated; family situation lacking in love and support; lonely, empty; hostility, hatred toward family; never experienced love relationship

Sc2—Emotional Alienation 11 items

High scores suggest: depression, despair; wishes he or she were dead; frightened, apathetic

Sc3—Lack of Ego Mastery, Cognitive 10 items

High scores suggest: fears losing mind; strange thought processes; feelings of unreality; problems with concentration, attention

Sc4—Lack of Ego Mastery, Conative 14 items

High scores suggest: fears losing mind; strange thought processes; feelings of unreality; problems with concentration, attention

Sc5—Lack of Ego Mastery, Defective Inhibition 11 items

High scores suggest: feels out of control of emotions, impulses; restless, hyperactive, irritable; laughing or crying episodes; may not remember previously performed activities

Sc6—Bizarre Sensory Experiences 20 items

High scores suggest: feels body changing in unusual ways; hallucinations, unusual thoughts, external reference, skin sensitivity, weakness, ringing in ears, etc.

Scale 9 Hypomania

Ma1—Amorality 6 items

High scores suggest: sees others as selfish, dishonest and feels justified in being this way; derives vicarious satisfaction from manipulative exploits of others

Ma2—Psychomotor Acceleration 11 items

High scores suggest: accelerated speech, thought processes, motor activity; tense, restless; feels excited, elated without cause; easily bored; seeks out excitement; impulse to do harmful or shocking things

Ma3—Imperturbability 8 items

High scores suggest: denies social anxiety; not especially sensitive about what others think; impatient, irritable toward others

Ma4—Ego Inflation 9 items

High scores suggest: unrealistic self-appraisal; resentful of demands made by others

The Harris–Lingoes content subscales are used to provide the interpreter

with clues to the specific problem dimensions that contribute to the high elevations

on the scale. For example, if the patient has a high score on scale 8, say a

T score of 80, an inspection of the Harris–Lingoes subscales might show that

the individual's score on Subjective Depression is contributing substantially to the overall score. The relative prominence of Subjective Depression in the

individual's clinical picture suggests that themes related to low mood should be given priority in the test interpretation.

The Harris–Lingoes subscales are interpreted according to the content of the

specific scale on which they are contained. Interpretation proceeds by examining

the relative contribution of the subscales to the overall elevation found on

the significantly elevated clinical scale. For example, if the D scale is elevated

above a T score of 65, then the most prominent subscale elevations (those also above $T = 65$) would be considered salient for interpretation.

The value of clarifying the meanings of MMPI-2 scale elevations by evaluating subscale content can be seen in the case illustration that follows. The MMPI-2 Pd scale elevations are usually thought to be stable and unchanging over time.

The case illustrated in Figure 5.2 provides some useful additional interpretive information about scale 4.

Restructured Clinical (RC) Scales

Demoralization (RCd)

Items: 24; 22 keyed True

Major Internal Correlates: RCd is overwhelmingly saturated with the First Factor, sharing 14 items (58% of RCd) with A, with which it correlates at an average .93 among the five clinical samples in Tellegen and Ben-Porath (2008). However, unlike A, which shares 7 items with ANX (18% of A) and 9 items with DEP (23% of A), RCd shares only 4 items with ANX (10% of A, 17% of RCd) and 11 items with DEP (28% of A, 46% of RCd). Among the same Tellegen and Ben-Porath samples, the average correlation between RCd and DEP (.93) is the same as that between RCd and A. The data presented in Tellegen et al. (2003, pp. 43–52) confirm a closer relationship between RCd and rated depression than that for RC2. This depressive bias of RCd and its corresponding lack of breadth, at least relative to A and other markers for the First Factor, has been the subject of comment by Nichols (2006a, pp. 129–131; 2006b, pp. 173–174). Description: Items reflect dysphoria; anxiety, impotence, guilt, and self-doubt; and indecision with a tendency to give up in the face of stresses. As in the case of A, RCd begins to top out as T-scores reach about 80. Interpretation: See A. As noted previously, despite its depressive bias RCd remains a viable marker for the First Factor. High scorers may be described as dysphoric if not depressed, as lacking initiative and self-confidence, and as functioning at a substantially reduced level of efficiency and competence. They carry a sense of guilt, failure, helplessness, and desperation, and they feel distracted and overwhelmed. They tend to retreat if not collapse under stress. Low Scores: Suggest contentment, optimism, adequate self-esteem, and a sense of confidence in meeting the stresses of everyday life. Most Useful Comparisons: High scores: DEP and A especially; also ANX, FRS1, OBS, LSE, WRK and NEGE. Low scores: Same as for high scores.

The RCd scale serves as a measure of general distress and emotional discomfort/turmoil that an individual is experiencing. The scale contains 24 items, with 22 keyed True. Thus, elevations on this scale can be affected by an All-True or All-False response set. Males in the normative sample scored significantly lower than females, although the effect size for the difference is small (see Table 10.4).

Correlates

Among psychiatric inpatients, Handel and Archer (2008) found that elevated RCd scores were positively related to suicide attempts, as well as to depression, anxiety, guilt, and blunted affect, as measured by the Brief Psychiatric Rating Scale (BPRS; Overall & Gorham, 1988). Arbisi, Sellbom, and Ben-Porath (2008) also found positive correlations with suicidal ideation and attempts, decreased energy, depression, anxiety, decreased sleep, and hopelessness among male VA inpatients and male and female community medical center inpatients. Tellegen and Ben-Porath reported the following correlates for inpatient men and women: cocaine abuse; depression and tearfulness; suicidality; decreased sleep, appetite, and energy; feelings of guilt, hopelessness, and worthlessness; poor concentration; loss of interest; and antidepressant medication. Among those seeking outpatient psychiatric or psychological care, Sellbom, Graham, and Schenk (2006) found moderate to strong positive relationships between RCd scores and depression, somatization, paranoia, anxiety, and mania. Sellbom, BenPorath, and Graham (2006) found small, but significant, relationships between RCd and current Global Assessment of Function scores (this was a negative relationship), depression, interpersonal sensitivity, and insecurity. Binford and Liljequist (2008) found positive relationships between RCd scores and depressed mood, suicidal ideation, and sleep problems. Simms et al. (2005) found positive correlations for RCd scores and negative temperament, mistrust, and self-harm, as measured by the Schedule for Nonadaptive and Adaptive Personality (SNAP) (Clark, 1993), in samples of military veterans and college psychology clinic clients. Tellegen and Ben-Porath (2011) reported that RCd scores are positively correlated with descriptions of insecure, anxious, pessimistic, and depressed for males. Correlates for outpatient females included depressed. Among non-patients, Forbey and Ben-Porath (2008) reported moderate to strong relationships between RCd scores and measures of depression and anxiety. Among the earlier MMPI-2 scales, RCd is highly correlated with DEP at .94 and non-K-corrected Pt at .93 (Greene, 2011).

Interpretation

In general, non-elevated scores on RCd indicate someone who is not experiencing a significant amount of psychological distress. As scores begin to elevate above a T-score of 65, individuals tend to report more dissatisfaction with their current situation and are likely to feel sad and anxious. Individuals with scores in this range see little chance of their situation improving in the future. As scores increase, above a T-score of 75 we are likely to encounter individuals who feel unable to cope or are overwhelmed with their current situation, and are experiencing significant clinical distress and turmoil. Even more so than those with scores below 75, they feel that their future is bleak. Depression is more likely when scores are this high. Individuals with scores in this range should be thoroughly evaluated for suicide risk.

Somatic Complaints (RC1)

Items: 27; 11 keyed True Major Internal Correlates: Highly saturated with the somatic component of the MMPI-2 item pool, RC1 is overwhelmingly redundant with Scale 1 and HEA, sharing 20 items each with both scales (4 of 5 with HEA1, 8 of 12 with HEA2, and 2 of 6 with HEA3). It also shares 3 of the 11 items on D3, 13 of the 17 items on Hy4, and 7 of the 20 items on Sc6. Its correlations with Scale 1, HEA, and Hy4 are in the mid-.90s. Description: Items reflect a broad range of somatic complaints, with an emphasis on neuromuscular and GI problems, head, neck, and chest pain, and sensory problems. Interpretation: High scores reflect concern or preoccupation with sensorimotor and gastrointestinal functioning, pain, and/or general health status. As in the case of Hy4, symptoms are fairly discrete and often dramatic. About half of the symptoms lend themselves to iconic or metaphoric use, especially through wording like, “lump in my throat,” “attacks of nausea,” “hurt all over,” “a tight band around my head,” “my hand shakes,” “pains over my heart,” “muscles twitching,” “dizzy spells,” and “my heart pounding.” The language of these items is more dramatic—even flamboyant—than is typical for the somatic portion of the MMPI-2 item pool. These and similar items may have connotations of attention seeking in some cases. They have an arresting quality and may be subject to colorful elaboration on interview. That is, they are easily pressed into service as components of a story that the patient wishes to relate, and one that is likely to have a relatively easily discernible latent message. Low Scores: Freedom from somatic preoccupations in particular and health concerns more generally. Most Useful Comparisons: High scores: Hy4 especially, Sc6, Scale 1, and HEA1. Check ANX and DEP. Low scores: See discussion of low scores under Scale 1.

Tellegen et al. (2003, p. 54) noted that the RC1 scale “bears the strongest resemblance to its Clinical Scale counterpart” (Hs). RC1 contains 27 items, 20 of which are shared with clinical Scale 1, with which it correlates at .96, and with HEA at .95 (Greene, 2011). The seven new items’ content refers to head pain, muscle or movement dysfunction, speech problems, and having a lump in one’s throat. Eleven items are keyed True and the remaining 16 keyed False. Thus, this scale is not particularly susceptible to an All-True or All-False response set. Females in the normative sample scored significantly higher than males, although the effect size for the difference was small (see Table 10.4).

Correlates

Among the correlates for psychiatric inpatients are chronic pain, along with decreased sleep, energy, and appetite (Arbisi et al., 2008). Handel and Archer (2008) reported physical illness, physical problems, somatic concerns, and suicide attempts among the correlates of higher scores on RC1. Tellegen and Ben-Porath (2011) reported that RC1 scores were positively correlated with problems of suicidality and depression, along with antidepressant medication among inpatient women at the time of admission, but not in outpatient men. Correlates for inpatient men included

decreased sleep, appetite, and energy among those treated at a community hospital, and chronic pain in those treated at a VA medical center. Additional correlates for females treated at a community hospital include depressed mood; decreased sleep, appetite, and energy; suicidal ideation; and chronic pain. Somatization, depression, and anxiety were reported by Sellbom and colleagues (Sellbom, Ben-Porath, & Graham, 2006; Sellbom, Graham, & Schenk, 2006) among outpatient clients. Simms et al. (2005) reported moderate positive correlations between RC1 scores and negative temperament and self-harm on the SNAP among their two samples. Tellegen and Ben-Porath (2011) included correlates of anxious, pessimistic, depressed, and somatic symptoms for both male and female outpatients. Forbey and Ben-Porath (2008) reported a moderate correlation between RC1 scores and scores on a somatization screening instrument among non-patient college students.

Interpretation

In general, this scale reflects a preoccupation with physical functioning, although some studies have shown depressive and suicidal correlates. Elevations on RC1 can occur when an individual has genuine physical or somatic complaints; thus, an elevation on this scale should not automatically lead one to assume hypochondriasis or a somatization disorder. Non-elevated scores on this scale usually reflect an absence of significant physical complaints, whereas elevated scores reflect their presence. These are often of a gastrointestinal or neurological nature. Complaints of head pain are not uncommon, nor are complaints of fatigue and a loss of energy. Subjective reports of depression are also associated with high scores. As scores elevate above a T-score of 75, we begin to see individuals who are more likely to respond to psychological distress with physical symptoms; further, they are likely to reject psychological explanations for their symptoms, especially if RC1 is elevated in isolation. The degree to which individuals with elevations in this range are preoccupied with their physical functioning is unusual among individuals with bona fide physical problems.

Low Positive Emotions (RC2)

Items: 17; all keyed False Major Internal Correlates: RC2 is highly correlated with INTR at .88, with which it shares 9 items. It shares only 8 items with D ($r = .82$), 5 on D1. Description: Items reflect the loss of self-efficacy and pleasure (anhedonia), anergia, a sense of disengagement, a lack of self-confidence, and pessimism, rather than depressed mood (sad, blue, etc.). Interpretation: High scores reflect withdrawal and a lack of drive, energy, interest, and motivation. In addition to depression, there may be complaints of anxiety and an inability to complete normal tasks and duties. As with elevated scores on Scale 2 and DEP, inquiry into suicidal ideation, past gestures and attempts, and plans is necessary. Less sensitive to depression than Scale 2 and DEP (Binford & Liljequist, 2008; see also Tellegen et al., 2003, pp. 43–47). Low Scores: Suggest optimism, buoyancy and social interest, self-confidence, energy, and

engagement; very low scores, as in the case of INTR, may reflect hypomanic elation. Most Useful Comparisons: High scores: INTR especially, DEP, DEP1, Si1, SOD1. Low scores: INTR, Scale 9.

As RCd corresponds to the negative emotionality aspect of Watson and Tellegen's (1985) model of affect, RC2 corresponds to positive emotionality aspect, specifically, the relative lack of positive emotions. According to this model, negative affect is associated with both depression and anxiety, but a lack of positive affect is a distinguishing feature of depression (Watson, Clark, & Carey, 1988). When extracting items for the seed scale, two clear dimensions emerged from clinical Scale 2: a demoralization dimension, and a positive dimension that was negatively keyed. Of the 57 items on clinical Scale 2, only 8 are shared with RC2, or just under 50 percent of RC2's items. RC2 contains 17 items, all keyed False; thus, this scale is particularly susceptible to an All-False response set. There was no significant difference on raw scores between females and males in the normative sample (see Table 10.4). Among other scales of the MMPI-2, RC2 is correlated with INTR at .88 (Greene, 2011).

Correlates

Handel and Archer (2008) noted positive relationships with suicide attempts, depression, psychomotor retardation, blunted affect, and emotional withdrawal among psychiatric inpatients. Arbisi et al. (2008) reported depression and a wide range of accessory symptoms among inpatients at a community medical center; among male VA psychiatric inpatients, however, only depression was associated with RC2 scores. Tellegen and Ben-Porath report positive correlations between RC2 scores and depression, suicidality, and antidepressant medication in male and female inpatients. Additional correlates for males and females at a community hospital include decreased sleep, loss of interest, anhedonia, decreased energy, poor concentration, suicidal ideation, and feeling helpless, hopeless, and/or worthless. High RC2 scores were associated with a history of a suicide attempts in men; in women, high scores were associated with a history of a suicide plan, although not with a history of attempts. Among outpatients, depression has been positively correlated with scores on RC2 (Binford & Liljequist, 2008; Sellbom, Ben-Porath, Graham, 2006; Sellbom, Graham, Schenk, 2006). Other correlates include suicidal ideation, sleep problems (Binford & Liljequist, 2008), negative temperament (Simms et al., 2005), worries about the future (Forbey & Ben-Porath, 2007); loss of motivation (Forbey & Ben-Porath, 2007; Sellbom, Graham, & Schenk, 2006), and introversion (Sellbom, Graham, & Schenk, 2006). Tellegen and Ben-Porath (2011) include the following among the correlates for RC2 scores in outpatient men: anxious, depressed, sad, self-doubting, self-degrading, self-punishing, preoccupied with health concerns, multiple somatic complaints, fatigue, acute psychological turmoil, difficulty concentrating, self-doubting, feels that life is a strain, fear of losing control, sleep disturbance, lonely, worrier, feels pessimistic and hopeless, feels like a failure, and feeling one is getting a raw deal from life. For women, the correlates include: sad, tearful, feels

pessimistic and hopeless, self-doubting, selfdegrading, self-punishing, feels like a failure, feels that life is a strain, socially awkward and insecure, lonely, sleep disturbance, and fatigue. Ranson, Nichols, Rouse, and Harrington (2009) reported that in two large samples of Midwestern undergraduates (Total N = 1,202) RC2 and Si predicted scores on the Wisconsin Physical and Social Anhedonia Scales (Kwapil, Chapman, & Chapman, 1999) about equally well, and less well than INTR, respectively, across all comparisons.

Interpretation

The scale essentially measures a lack of engagement in the positive emotional aspects of life, as well as in the types of activities associated with positive emotionality. Individuals scoring low ($T < 39$) are often described as confident, energetic, socially engaged, and optimistic. Individuals with elevated scores ($T > 65$) are at increased risk for depression. They find little pleasure in the activities of their lives or in social interactions. They may appear to be disengaged from those whom they have been close to in the past. They worry about a future that they view as bleak, and see little possibility for improving the future; thus, they have little motivation to effect change. They report a lack of energy, yet have difficulties with sleep; they may evidence psychomotor retardation. As scores increase beyond a T of 75, the possibility of major depression increases, as does the likelihood of suicidal ideation. Individuals scoring high on this scale should be carefully screened for suicidal thoughts.

Cynicism (RC3)

Items: 15; all keyed True Major

Internal Correlates: RC3 is overwhelmingly redundant with CYN and CYN1, with which it shares 12 and 11 items, respectively, and correlates with both in the low to mid-.90s. It is essentially uncorrelated with Scale 3, with which it shares only 5 items, all on Hy2, but scored in reverse.

Description: Items convey mistrust if not distrust and reflect the view that others are selfish, motivated only by self-interest, and that close relationships are commonly marked by infidelity.

Interpretation: See CYN1 . Low Scores: See CYN1 .

Most Useful Comparisons: High scores: CYN, CYN1, Ho. Low scores: S1, Hy2, Pa3.

Tellegen et al. (2003, p. 55) described RC3 as “represent[ing] a circumscribed component of clinical Scale 3 that we singled out as distinctive.” All 15 items are keyed True; thus it is quite sensitive to an All-True response set. RC3 shares 5 items with Hy (all from Hy2, Need for Affection), and 12 items with the Cynicism (CYN) content scale (11 of which appear on CYN1, Misanthropic Beliefs), with which it correlates at .93 to .95 among the Tellegen and Ben-Porath samples), and 10 items with the Hostility (Ho) scale, with which it correlates .85 (Greene, 2011). In addition,

it shares four items with Pa3, Naïveté. Note that the items on RC3 are reverse-scored as compared to clinical Scale 3, as Tellegen et al. stated a wish for higher scores to reflect higher levels of cynicism; thus, scores on RC3 may be inversely related to scores on Hy. Males in the normative sample scored significantly higher than females, although the effect size for the difference was small (see Table 10.4).

Correlates

No correlates of moderate or greater strength have been reported among inpatient samples for RC3 (Arbisi et al., 2008; Handel & Archer, 2008; Tellegen & Ben-Porath, 2011). Among outpatients, modest positive relationships have been reported for mistrust (Sellbom, Ben-Porath, & Bagby, 2008; Sellbom, Graham, & Schenk, 2006; Simms et al., 2005), sleep disturbance in men (Tellegen & Ben-Porath, 2011), and anger (Sellbom et al., 2008) as well as high scores on the SNAP paranoid, schizotypal, borderline, and narcissistic personality disorder scales (Simms et al., 2005). Scores on RC3 were found to be negatively related to measures of agreeableness (Sellbom et al., 2008) and needs to achieve. Among non-patients, negativism has been shown to be moderately correlated (Forbey & Ben-Porath, 2008; Sellbom & Ben-Porath, 2005) with scores on RC3, as has Machiavellianism (Ingram, Kelso, & McCord, 2011) and alienation (Ingram et al., 2011; Sellbom & Ben-Porath, 2005). In addition, Sellbom and Ben-Porath have noted that positive well-being is negatively correlated with RC3 scores. Greene (2011) has suggested that although few correlates exist for RC3, the theme of the items is one of occasional anger. Unlike the items on RC6, which will be discussed later, the items on RC3 are not self-referential.

Interpretation

Individuals who score low ($T < 39$) on RC3 have been described as seeing others as trustworthy. Low scores on this scale may also reflect naïveté or gullibility. High scorers, on the other hand, are described as being hostile and seeing others as essentially untrustworthy. They may feel alienated from others and, because of their inability to trust others, may have difficulty forming therapeutic alliances with caregivers. Because they often see others as essentially “being in it only for themselves,” they may also be willing to take advantage of others.

Antisocial Behavior (RC4)

Items: 22; 16 keyed True Major

Internal Correlates: RC4 is correlated with AAS at .77, with which it shares 7 items, and with ASP2 at .80, with which it shares 5 items. It overlaps Scale 4 by 9 items (5 on Pd2, 3 on Pd1), and DISC by 8 items ($r = .68$).

Description: Items admit substance use/abuse and the untoward consequences thereof (e.g., breaking things), delinquent if not criminal conduct (theft), truancy and unruly conduct in school, and conflicted

and unpleasant family relationships. About three-quarters of the items are historical and phrased in the past or past perfect tense.

Interpretation: Scores in a range of about T-60 to T-65 for men or T-65 to T-70 for women are ambiguous as such scores may be achieved by endorsing items related to either substance abuse alone (usually), or delinquency alone (rarely). However, as scores reach about T-80 (T-85 for women), it becomes likely that both sets of items have been endorsed, at least to some extent. At these levels, a relatively broad level of antisocial inclination, if not conduct, is suggested, with emotional and behavioral undercontrol, nonconformity, antagonism toward authority figures, acting out in criminal, sexual, hostile, and/or substance abusive ways, and avoiding responsibility, and their relations with others are likely to be marked by opportunism, expediency, infidelity, lying, cheating, and manipulation. The eight samples given in Tellegen and Ben-Porath (2008), demonstrate that RC4 generally predicts external criteria for substance use/abuse/dependence at least as well as it does juvenile and adult antisocial conduct, even among criminal defendants (pp. 214–227). Some preliminary evidence suggests that RC4 may have some advantages over AAS, MAC-R, and ASP in predicting substance abuse (Stransky, 2006; K. R. Young, 2009). Therefore, predictions of antisocial conduct, whether juvenile or adult, will be more reliably made when Pd2, DISC, and, especially, ASP2 are concurrently elevated. Low Scores: Suggest the absence of substance abuse/dependence, conformity to legal and ethical mores, adequate behavioral controls, and generally straightforward and respectful relations with others. Most Useful Comparisons: High scores: AAS, Pd2, ASP2, DISC; secondarily, MAC-R and APS; ASP, ASP1, CYN, Pd1, FAM. Low scores: AAS, Pd2, ASP2, DISC, Re, GF.

Tellegen et al. (2003) suggested that clinical Scale 4 contained an abundance of items pertaining to feelings of alienation and demoralization, and that RC4 provides “an unconfounded assessment of an individual’s antisocial tendencies” (p. 56). RC4 contains 22 items, with 16 keyed True. Nine items remain from clinical Scale 4, eight items are shared with the Disconstraint PSY–5 scale (DISC; four of these also overlap clinical Scale 4), and seven items are shared with the Addiction Acknowledgement supplemental scale (AAS; two of these also overlap with clinical Scale 4), with which it correlates at .79 (Greene, 2011). Males in the normative sample scored significantly higher than females; the effect size for the difference was moderate (see Table 10.4). Greene (2011) has suggested that RC4 correlates with scales in four categories: (1) antisocial attitudes and behaviors, (2) disconstraint, (3) substance abuse, and (4) family problems. Bolinskey and Nichols (2011) have expressed concern that the addition of items clearly related to substance abuse, in particular, may have caused an unintended “drift” away from the construct measured by the seed items (i.e. antisocial behavior) and made it possible for elevations on the scale to occur solely as a result of substance-related problems. Tellegen and Ben-Porath (2011), in fact, reported higher correlations for substance abuse problems and diagnoses than for any history of legal issues or diagnosis of antisocial personality disorder for both males and females, and in both outpatient and inpatient samples. Bolinskey, Trumbetta, Hanson, and Gottesman (2010), however, reported modest positive correlations between RC4 scores in adolescence and criminal behavior as an adult.

Correlates

Among inpatients, positive correlations have been found between RC4 score and substance issues (Arbisi et al., 2008; Ben-Porath & Tellegen, 2008; Handel & Archer, 2008). Legal issues have also been associated with higher scores on RC4 (Arbisi et al., 2008; Ben-Porath & Tellegen, 2008; Handel & Archer, 2008). Handel and Archer (2008) also noted a positive correlation with hostility. Ben-Porath and Tellegen (2011) reported that higher scores are associated with abusive behavior in men, but not in women. Tellegen and Ben-Porath (2011) note a positive correlation between RC4 scores and suicidal ideation. In outpatient samples, the primary RC4 correlates have been found to be substance issues (Binford & Liljequist, 2008; Sellbom, Ben-Porath, & Graham, 2006), depression (Binford & Liljequist, 2008), mistrust, and manipulateness (Simms et al., 2005). Tellegen and Ben-Porath (2011) found that both males and females with high scores on RC4 were more likely to have been the victims of physical abuse than individuals with low scores; males were more likely to be physically abusive. Women with high scores were more likely to have been victims of sexual abuse. Tellegen and Ben-Porath also reported that both men and women felt that their family lacked love.

Interpretation

Individuals scoring low ($T < 39$) on RC4 report a below average history of antisocial behavior and substance abuse. Individuals with elevated ($T > 65$) scores, however, are more likely to have a history of antisocial behavior and/or substance abuse. They are likely to have a history of failing to conform to social rules and norms, and to be described as argumentative, critical, or antagonistic in their relations with others. Thus, they often have a poor history of interpersonal relationships. Their family relationships tend to be strained or distant. They frequently have a history of poor achievement.

Ideas of Persecution (RC6)

Items: 17; 16 keyed True

Major Internal Correlates: RC6 is overwhelmingly redundant with Pa1, with which it shares 12 of the latter's 17 items and correlates in the low .90s. It also correlates in the low to mid-.80s with BIZ and PSYC, sharing 10 items with each (7 on BIZ1).

Description: Like the items of Pa1, the RC6 items emphasize delusions of control and ideas, if not delusions, of persecution (Cf. Pf3 and Pf4). A few additional items reflect resentment and ideas of reference.

Interpretation: See Pa1. Low Scores: See Pa1.

Most Useful Comparisons: High scores: Pa1, Pf3, Pf4; secondarily, BIZ, BIZ1, PSYC, CYN, CYN2. Low scores: Hy2, Pa3.

RC6 contains 17 items, with 16 keyed True; as such, it is susceptible to an All-True response set. RC6 shares 13 items with clinical Scale 6 (12 on Pa1, Persecutory Ideas, with which it correlates at .83 to .92 among the Tellegen and Ben-Porath [2011] samples), 10 with Bizarre Mentation (BIZ; 8 of these also appear on clinical Scale 6), and 10 with the PSY-5 Psychoticism scale (PSYC; 9 of these also appear on clinical Scale 6). Males in the normative sample endorsed significantly more items than did females, although the magnitude of the difference was small (see Table 10.4). All but one of the RC6 items are self-referential, in contrast to the items on RC3 which are not. Tellegen et al. (2003) note that, as compared to clinical Scale 6, RC6 is less saturated with demoralization and that an elevation of clinical Scale 6 in the absence of an elevation of RC6 would suggest that the respondent is not experiencing clear persecutory ideation. Greene (2011) has suggested that the scale broadly correlates with measures of psychoticism and infrequent responses.

Correlates

Behavioral correlates that have been reported among inpatient samples include paranoid suspicions, delusions, and hallucinations (Arbisi, Sellbom, & Ben-Porath, 2008). Handel and Archer (2008) reported conceptual disorganization, suspiciousness, and hallucinatory behavior in their inpatient sample. Tellegen and Ben-Porath (2011) reported positive correlations for suspiciousness, ideas of reference, delusions, and hallucinations among inpatient men and women. Among individuals seeking outpatient treatment, Sellbom, Graham, and Schenk (2006) reported a positive relationship between mistrust and RC6 scores. Simms et al. (2005) reported positive correlations between RC6 scores and measures of mistrust and eccentric perceptions. Sellbom, Ben-Porath, and Graham (2006) reported modest correlations with depression, global psychopathology, interpersonal sensitivity, anxiousness, and insecurity; interestingly, they did not report a significant relationship with suspiciousness. Tellegen and Ben-Porath (2011) reported the following correlates for males: feels that life is a strain, does not get along with coworkers, depressed, and self-degrading; they reported a negative relationship with high achievement needs. For women, they reported negative relationships with high aspirations, achievement needs, communication effectiveness, likability, having many interests, and creating a good impression. Among non-patients, Forbey and Ben-Porath (2008) reported modest positive relationships between RC6 scores and measures of somatization, depression, and magical thinking. Sellbom et al. (2008) reported a negative relationship between RC6 scores and a measure of trust.

Interpretation

Low scores on RC6 are not interpreted. High scores may reflect significant persecutory ideation, such as the belief that others are out to harm one's self. As scores increase, the probability of paranoid delusions or other psychotic symptoms increases. Individuals who score high on RC6 are often described as being suspicious of others and their motives. They see malicious intent in the actions of others and often blame others for their difficulties. Their mistrust of others can cause difficulties in interpersonal relationships; thus, these individuals are often alienated from others. As the T-score increases above 80, the individual should be carefully assessed for paranoid delusions and hallucinations.

Dysfunctional Negative Emotions (RC7)

Items: 24; all keyed True

Major Internal Correlates: RC7 is correlated with A, NEGE, and Scale 7 in the mid- to high .80s, and shares 10, 7, and 8 items with these scales, respectively. In each of the five clinical samples in Tellegen and Ben-Porath (2008), RC7 is more highly correlated with A (Mean = .89) than with Scale 7 (Mean = .87), and RCd is more highly correlated with Scale 7 (Mean = .90) than is RC7 (Mean = .87). The proportion of item overlap between RC7 and A is likewise greater (10 items, 10/24 = 42%) than between Scale 7 and A (13 items, 13/48 = 27%). Moreover, the proportion of Scale 7 items retained in RC7 (8 items, 8/24 = 33%) also falls below the proportion of RC7/A overlap. In short, in RC7, First Factor variance has actually increased over that of Scale 7, a scale already known to be highly saturated with this source of variance, at least as measured by A (and at least four other markers for the First Factor; see Nichols [2006a, pp. 131–132] and Ranson, Nichols, Rouse, & Harrington [2009, p. 127], and even when measured by RCd.

Description: Items reflect anxiety, worry, chronic apprehension, and a sense of dread, but with concurrent hypersensitivity, irritability, impatience, and a quickness to anger. Interpretation: High scorers present as depressed, anxious, tense, and overwhelmed, and with a sense of exasperation with both themselves and others. They are likewise troubled by a lack of cognitive control, with ruminations and preoccupations that they know to be undirected, fruitless, and largely irrational. They generally also recognize their irritability and anger to be excessive and unwarranted (ego-dystonic) but feel helpless to contain it. Complaints of disturbed sleep are common. Intimates may describe the patient as “difficult to be around.” At very high elevations (~ T-80), incipient psychoticism is often in evidence, with esoteric preoccupations, ideas of reference, plainly irrational fears, and the like. Low Scores: Suggest adequate emotional and cognitive control, perseverance in the face of obstacles, flexibility and an ability to handle stresses in stride, a quality of comfort in one's own skin, and relatively easygoing and harmonious relations with others. Most Useful Comparisons: High scores: The interpretive description above will fit best when RC7 exceeds RCd and A; ANX, FRS1, DEP, DEP4, OBS, ANG, ANG2, TPA1, LSE, SOD2, WRK, NEGE. Low scores: GM, K, Es.

RC7 was conceptualized as a scale to measure reports of negative emotional experiences, such as anxiety, anger, or fear. Of the 24 items in RC7, 8 are shared with clinical Scale 7, and 10 with Welsh's A (4 of these items also overlap clinical Scale 7). Greene (2011) reports a correlation between RC7 and A of .90 and notes that the various scales with which RC7 evidences very high (i.e. > .80) correlations represent only the broad category of general distress. Indeed, Bolinsky and Nichols (2011) have suggested that RC7 may be even more saturated with first-factor variance than clinical Scale 7, which they attribute as much to difficulties in the creation of the original scale as to problems unique to RC7. The saturation of RC7 with the first-factor variance is not unexpected, given that all seven of its seed items overlap by at least one and as many as six items ($M = 2.1$) with three independent first-factor markers described by Nichols (2006). RC7 contains 24 items, all keyed True. As with other scales, one should carefully evaluate the effects of response sets when interpreting elevations on this scale. Females in the normative sample evidenced a small, but significant, effect for endorsing more items than did their male counterparts (see Table 10.4).

Correlates

Handel and Archer (2008) reported positive relationships between RC7 scores and anxiety, somatic concerns, and a history of sexual abuse among inpatients. Arbisi, Sellbom, and Ben-Porath (2008) reported decreased sleep, flashbacks, suicidal ideation, and antidepressant medication among the correlates of RC7 scores among inpatients. Tellegen and Ben-Porath (2011) list antidepressant medication among the correlates for men, and antidepressant medication, depression, and suicidal ideation among the correlates for women in an inpatient setting. Among those seeking outpatient treatment, Sellbom, Graham, and Schenk (2006) found RC7 scores to be positively related to mistrust, depression, anxiety, and somatization. Simms et al. (2005) reported correlates of negative temperament, mistrust, manipulateness, aggression, self-harm, eccentric perceptions, and detachment, as measured by the SNAP, within an outpatient sample. Scores on RC7 were also positively related to scores on the paranoid, schizotypal, borderline, narcissistic, avoidant, and dependent personality scales of the SNAP. Within their sample of outpatients, BenPorath and Graham (2006) reported moderate correlates of global psychopathology, depression, interpersonal sensitivity, anxiety and insecurity. Among the correlates for outpatient men offered by Tellegen and Ben-Porath (2011) were acute psychological turmoil; anxiety; insecurity; sadness; tearfulness; moodiness; pessimism; preoccupation with health problems; difficulty concentrating; feeling overwhelmed, lonely, inferior, like a failure, and that one gets a raw deal from life; feeling as though one's family is lacking in love and resenting family members; keeping others at a distance; and being self-punishing and self-degrading. Poor stress tolerance was also positively correlated with RC7 scores. For outpatient females, Tellegen and Ben-Porath reported positive relationships with the tendency to give up easily, as well as with suicidal ideation. Negative relationships were reported with stress tolerance, self-reliance, high aspirations, and having many interests. Among non-patients, RC7 scores have been

correlated with measures of trait anxiety, trait anger, obsessive–compulsiveness, and social phobia (Forbey & Ben-Porath, 2008). Sellbom et al. (2008) reported positive relationships with anxiety, angry-hostility, self-consciousness, and vulnerability. They reported negative relationships with trust, conscientiousness, and competence.

Interpretation

Greene (2011) suggests that due to the high correlation between RC7 and other measures of first-factor distress, only one such scale should be interpreted. We agree with this observation and note, again, that one should never use a score as confirming evidence for a high score on a scale with which it is redundant. Low scores ($T < 39$) on RC7 are obtained from individuals who report little or no general distress. High scores, on the other hand, reflect significant negative emotional experiences, such as anxiety, fear, or irritability. Individuals who score high on RC7 can often be described as feeling sad and unhappy. They are prone to guilt and have a tendency to be self-critical. They worry excessively and are very insecure; as such, they are prone to perceive criticism where it may not exist. They are pessimistic; they expect to fail and believe that they have failed. They frequently worry and have sleep difficulties, including nightmares. They may feel overwhelmed and incapable of coping with their current situation. Particularly high scores ($T > 80$) reflect significant emotional discomfort and helplessness; a referral for medication evaluation may be warranted.

Aberrant Experiences (RC8)

Items: 18; 17 keyed True

Major Internal Correlates: RC8 correlates in the low .90s with BIZ, with which it overlaps by 12 items (4 on BIZ1, 6 on BIZ2), and in the low to mid-.80s with PSYC, with which it shares 8 items. It shares 10 items with Scale 8 (9 on Sc6), and 11 items with DisOrg, with which it correlates at .94.

Description: RC8 is distinct among the standard complement of psychoticism scales (Pa, Sc, Ma, BIZ, PSYC) in avoiding the admixture of paranoid (e.g., delusions of control or persecution) and thought disorder/disorganization item content, the former content having been segregated to Pa1 and RC6. Scales 8, BIZ, and PSYC include 5, 8, and 8 of these paranoid items, respectively. The items of RC8 reflect anomalous sensory experience, experience described as “peculiar,” derealization, and 6 items more or less explicitly reference audio or visual hallucinations and first-rank symptoms (e.g., thought broadcasting). Three of the items (168, 182, 229) suggest dissociative episodes/crises that are probably not psychotic in nature but are more consistent with other psychiatric (panic, dissociation) or medical (intoxication, epilepsy) conditions.

Interpretation: High scorers are likely to present as disorganized if not hallucinated and manifestly psychotic, with anxiety, poor concentration and judgment, suspiciousness, delusion ideation (reference, persecution, control, etc.), and a history of alienation, hospitalization for mental disorder,

chemotherapy, and possible substance abuse. Low Scores: Largely the absence of the symptoms/complaints indicated by high scores.

Most Useful Comparisons: High scores: DisOrg, CogProb, BIZ, BIZ1, BIZ2, PSYC, RC6, Pa1, CYN2. Low scores: Same as high scores.

Tellegen et al. (2003) noted that the RC8 items describe a wide variety of symptoms, including sensory, perceptual, cognitive, and motor disturbances. RC8 is much less saturated with first-factor variance than is its clinical Scale 8 counterpart. Further, unlike scales such as BIZ or PSYC, the items of RC8 do not include paranoid content, as that construct was confined to RC6. RC8 contains 18 items, with 17 keyed True; thus, elevations are particularly sensitive to an acquiescent or All-True response set. Of these 18 items, 10 appear on clinical Scale 8, 8 on PSYC, and 12 on BIZ (4 on BIZ-1 and 6 on BIZ-2). No difference in mean item endorsement was observed between males and females in the normative sample (see Table 10.4). Nichols (2006) observed that RC8 reflects a good balance in content reflecting anomalous experience (e.g. de-realization and hallucinations) and Schneider's (1959) First Rank symptoms, such as thought broadcasting. He noted that there is no other MMPI-2 scale in which this content is better represented and concentrated. Greene (2011) reported a correlation between RC8 and BIZ of .91, and noted that the defining characteristics of those scales with which RC8 highly correlates are psychotic behaviors and symptoms, infrequent responses, and general distress.

Correlates

Handel and Archer (2008) reported that RC8 scores were positively related to ratings of conceptual disorganization, hallucinatory behavior, and unusual thought content among psychiatric inpatients. Others (Arbisi, Sellbom, & Ben-Porath, 2008) have also reported that hallucinations are associated with RC8 elevations in inpatient men and women. Sellbom, Graham, and Schenk (2006) reported RC8 correlates among outpatients that included bizarre experiences, paranoia, panic, anxiety, and mania. Simms et al. (2005) reported that RC8 scores were moderately correlated with ratings of negative temperament, mistrust, and eccentric perceptions. Among the correlates for male outpatients reported by Tellegen and Ben-Porath (2011) are anxiety, depression, somatic complaints, low achievement-oriented, sleep disturbance, feelings of failure, and difficulty making decisions. Correlates reported for female outpatients included a history of suicide attempts and sexual abuse, hallucinations, feeling disoriented, and a poor ability to cope with stress. Among non-patients, Forbey and Ben-Porath (2008) noted that RC8 scores were positively correlated with scores on the Magical Ideation (Eckblad & Chapman, 1983) and Perceptual Aberration (Chapman, Chapman, & Raulin, 1978) scales. Sellbom et al. (2008) reported that higher scores on RC8 were associated with lower scores on trust.

Interpretation

Low scores on RC8 should not be interpreted. Individuals who produce moderately elevated T-scores in the range of 65 to 74 may be exhibiting schizotypal characteristics. They are reporting unusual perceptions and thought processes, which may include hallucinations and/or delusional beliefs. They may exhibit impaired reality testing. They are often described as anxious or depressed. They have difficulty trusting others and are also likely to have difficulties in interpersonal and occupational functioning. As T-scores elevate above 75, the possibility of schizophrenia or another psychotic disorder increases, along with the degree of thought and perceptual disturbance. Referral for a medication evaluation, hospitalization, or intensive therapy should be considered.

Hypomanic Activation (RC9)

Items: 28; 27 keyed True

Major Internal Correlates: RC9 correlates .75 with Scale 9, with which it shares 8 items, 4 on Ma2, 3 on Ma4. It also correlates in the .65 to .70 range with AGGR, ANG, ANG1, TPA, TPA2, and Ho, sharing from 3 to 7 items with each. Its strongest negative internal correlates are D2, Hy2, and Hy5, in the -.40 to -.50 range. This pattern of correlates indicates that RC9 is heavily influenced, if not dominated, by variances related to anger, instrumental aggression, hostility, and vindictiveness.

Description: About one-third of the items reflect hostile aggression, a quickness to anger, vindictive reactions to perceived provocations, and a willingness to provoke and intimidate others. Another one-third connote elements of excitement, euphoria, racing thoughts, and stimulation seeking, especially in social contexts. Many of the remaining items suggest an inflated if not competitive and grandiose self-concept.

Interpretation: High scorers are likely to present as aggressive, provocative, and overbearing, and as irritable if not hostile. They have a low threshold for boredom, are intolerant of frustration, and are excitable and overreactive, seemingly unable to modulate their impulses. Behavior tends to be poorly organized and unstable. Self-esteem is likely to be inflated and entitled, if not grandiose. The predominant affect is typically irritable rather than inflated/euphoric, but the latter may be seen at lower scores, even as low as T-50, especially to the degree that Scale 9 exceeds RC9, and to the extent that Scale 9 exceeds INTR. Low Scores: Largely the absence of the symptoms indicated by high scores.

Most Useful Comparisons: High scores: Scale 9, ANG1, TPA2, AGGR, INTR, DISC, DisOrg. Low scores: Scales 2 and 7, INTR.

The items in RC9 have been described as measuring behaviors such as racing thoughts, increased energy, expanded mood, heightened self-regard, sensation-seeking, and irritability—all behaviors associated with hypomanic activation (Tellegen et al., 2003). RC9 contains 28 items, with all but one keyed True; it is therefore particularly sensitive to All-True or All-False response sets. It shares eight items with clinical Scale 9 and seven with the Aggressiveness (AGGR) PSY-5 scale (one of these items also overlaps clinical Scale 9). Males evidence a small, but significant effect for endorsing more items than their female counterparts in the normative sample (see Table 10.4). Greene (2011) has observed that scores on RC9 correlate most highly with scales that measure antisocial attitudes and behaviors, hypomania, and aggression. Bolinsky and Nichols (2011) suggested that the hypomanic activation core present in the seed items for RC9 may have been significantly diluted by the angry, vindictive, and aggressive content recruited into the scale in Step 4 of the RC scales' development. As a consequence, in some profiles an elevation on RC9 may be generated more on the basis of this scale's hostile content than by its hypomanic content.

Correlates

Tellegen and Ben-Porath (2011) report a history of cocaine abuse and a history of violent behavior among the correlates of RC9 scores for inpatient men. For inpatient women, they reported correlates of histories of substance abuse, and cocaine abuse, as well as a diagnosis of substance abuse or dependence. Handel and Archer (2008) reported substance abuse, conceptual disorganization, and excitement among the correlates of RC9 in a sample of psychiatric inpatients. Arbisi, Sellbom, and Ben-Porath (2008) reported that cocaine use was positively correlated with RC9 scores.

In a sample of individuals seeking outpatient treatment, Simms et al. (2005) reported manipulativeness, aggression, and disinhibition among the correlates of RC9 scores. Scores on RC9 were also strongly correlated with scales associated with antisocial, borderline, histrionic, and narcissistic personality disorders. Sellbom, Ben-Porath, and Graham (2006) reported that elevated RC9 scores were correlated with descriptions of clients as antisocial and aggressive. Sellbom, Graham, and Schenk (2006) reported mistrust and mania were associated with higher scores on RC9. Among non-patients, Forbey and Ben-Porath (2008) reported that higher RC9 scores were associated with higher scores on measures of general impulsivity, motor impulsivity, and activation. Sellbom et al. (2008) reported that RC9 scores were positively correlated with measures of angry-hostility, impulsiveness, and excitement-seeking. RC9 scores were negatively associated with scores on measures of agreeableness, trust, straightforwardness, compliance, modesty, and deliberation.

Interpretation

Individuals who score low ($T < 39$) on RC9 are reporting low levels of hostility, energy, and engagement with the environment. Individuals with elevated scores may be described as irritable or hostile. They report increased levels of energy and may experience racing thoughts. Individuals with high scores are likely to be high in sensation-seeking; they may have poor impulse control and be more inclined to engage in antagonistic and/or risky behaviors. They may exhibit antisocial behaviors and have problems with substance abuse. As T-scores increase above 75, the likelihood of a manic episode increases. A referral for a medication evaluation should be considered.

Subtle / Obvious

The Critical Item Approach

The most direct approach to assessing content themes in the MMPI is to examine the patient's actual responses to individual items. The *critical item approach*, as this strategy has been called, involves using individual MMPI items as a means of detecting specific content themes or special problems the patient is reportedly experiencing. The critical item approach assumes that the patient responds to items as symptoms or problems, and reports his or her feelings accurately. The critical item or pathognomic indicator is one of the earliest approaches to personality test interpretation. In fact, Woodworth (1920), in his pioneering work on the Personal Data Sheet, included what he called "starred items," or pathognomic contents, that were believed to have a particular significance if answered in a pathological direction.

Of course, evaluation of specific items by reading through the record is a cumbersome and confusing way of attempting to understand the content, since there are too many bits of information to readily organize and integrate. Consequently, the clinician needs some ways of organizing or hierarchically arranging the items in order of importance before examining specific items. Early critical item approaches, such as the Grayson Critical Items (Grayson, 1951) or the Caldwell Critical Items, were largely developed by their authors by simply reading through the items and selecting those believed to reflect particular problems. Neither of these early sets of critical items was ever validated to determine if the specific items used were tapping uniquely important problems. The items were simply adapted for clinical or computerized psychological test use on the basis of the clinician's hunch that the item measured highly significant or "critical" problem areas. There are two sets of MMPI-2 critical items that were empirically derived to aid the clinician in assessing specific problems of concern: the Koss-Butcher

Critical Item List and the Lachar–Wroble Critical Item List.

The Koss–Butcher Critical Item List

Koss and Butcher (1973) were concerned that the existing sets of critical items were being used as indicators of specific pathology without an empirical data base for such predictions. In other words, the Grayson and Caldwell item groupings were initially developed by a rational examination of the item pool and were not actually empirically related to clinical problems in a valid way.

Koss and Butcher (1973), Koss, Butcher, and Hoffman (1976), and Koss (1979) conducted empirical investigations of item responses and their relationships to psychiatric status for patients at admission to a psychiatric facility. They evaluated the effectiveness of the Grayson and Caldwell critical item lists for detecting crisis states and developed a new set of empirically based critical items that discriminated among presenting problems experienced by psychiatric patients at admission.

Koss and Butcher (1973) first defined several “crisis situations” that were frequently found among individuals seeking admission to a psychiatric facility. They interviewed several clinicians as to what were important crises that would require evaluation in clinical settings. Six crisis situations were thought to be particularly important because of their frequency or their significance:

1. Suicidal depression
2. Anxiety state
3. Threatened assault
4. Alcoholic crisis
5. Paranoia
6. Psychotic distortion

Koss and Butcher then reviewed presenting problems for more than 1,200 cases admitted to the Minneapolis Veterans Administration Hospital and grouped together individuals with similar problems. Then they performed an item analysis to detect MMPI items that discriminated the various crisis groups from each other and from a control group of general psychiatric patients. The resulting Koss–Butcher Critical Item List contains items that validly discriminated the crisis conditions.

The Koss–Butcher Critical Item List was expanded in the MMPI revision to incorporate new item contents of importance in the assessment of two major problem areas: substance abuse and suicidal threats. A number of new items have been added to the MMPI-2 for assessment of special problem areas, including

four new items that empirically separate alcohol- and drug-abusing patients from other groups, which have been added to the Alcohol Crisis group, and four new items dealing with depression and suicide, which have been added to the Depressed–Suicidal Crisis group.

The Lachar–Wrobel Critical Item List

In a subsequent study, Lachar and Wrobel (1979) replicated about two thirds of the Koss–Butcher list and developed an expanded critical item list to include several other crisis categories.

Use of Critical Items

The most appropriate use of critical items is for detecting specific problems or attitudes the patient is reporting that might not be reflected in the clinical profile elevations. In this way significant themes are highlighted and can be used to illustrate inferences from the clinical scales or code type information. A case illustration highlights the effectiveness with which groups of similar items can reflect particularly pertinent problem areas.

Welsch Code

Range	Code
>90	*
80-89	“
70-79	‘
60-69	-
50-59	/
40-49	:

The Next Step

DSM and Axis 1 Conditions

Scores on the six scales of psychosocial development represent outcomes of a sequential series of normative crises (Erikson, 1963) that occur during the years from infancy through early adulthood. The scales, however, do not examine those significant life events from a developmental perspective but instead as they exhibit themselves in adult

respondents' attitudes, beliefs, and value statements. Thus, they measure in the adult the persisting dynamics of earlier gains and losses that cast shadows resembling residues of the normative crisis resolutions. Neither the earlier outcomes nor their residues are static entities. They at all times are experienced as the balancing of dynamic forces that mirror the contrasting poles of each crisis. The balances are challenged continuously by ordinary vicissitudes of life circumstances that test the stability and resiliency of prior crisis resolutions. In these roles, the outcomes and residues repeatedly impress themselves in varied guises on the adult psyche and generate reactions.

ENGAGING THE PSYCHOSOCIAL CRISES

Consider next the processes whereby the outcomes and residues become parts of the individual's intra-psycho assets and liabilities. During earlier development, the phased appearance of each new normative crisis presents a qualitatively different kind of challenge. When a new crisis arrives, on the one hand, it entices the individual to strain toward the more mature prerogatives of the next stage by mastering its functional modalities. On the other hand, it discourages regressive clinging to the resolutions of prior phases. To the extent that respondents engage each emerging crisis as a gift of both challenges and opportunities for growth, they acquire coping resources. Furthermore, despite misgivings to the contrary, the prior resolutions are not actually abandoned. Instead, they are transformed and integrated into the new ways of interacting in spheres of both external and internal reality. Moreover, as the individual continues to engage reality by using the established modalities, the residues of earlier resolutions appear and reappear with regularity and thereby remain accessible to self-examination and self-disclosure. It is these recurring events and the feelings that accompany them that the Psychosocial scales enable the respondent to communicate. The following interpretations of the scales emanate from these understandings of the psychosocial dynamisms that remain at work.

Feels Cared for/Loved vs. Neglected/Disliked

The Cared For.

Highly Cared for persons say that they feel treated fairly and considerately by others. This outlook appears to have its roots in their families of origin. A more internal locus of control is suggested by readiness to accept personal responsibility for life circumstances rather than attributing them to external forces beyond their control. This perspective on life events has aptly been traced to feelings of personal efficacy (Piaget, 1972) and efficacy has been shown to eventuate in a sense of personal causation (De Charms, 1968). Accordingly, those who feel Cared for see others as more likely to be supportive, kind, sympathetic, and caring. In keeping with this, they describe themselves

as highly open and nonguarded in interpersonal contacts. They further believe that the people they encounter are predictable and act out of cordial motives nearly all of the time. These outlooks are associated with an inner certainty that others are likely to behave in a forthright and honest manner. That is, people are what they seem on the surface to be, without concealed motives and hidden designs. High scorers affirm that they try to treat others in keeping with these beliefs. Based on a pervasive view of others as basically good, extremely high scorers imply that they are abundantly trusting. Thus, at times, they may disregard obvious reality to the point of displaying a naive, Pollyannaish attitude of unbounded optimism. They prefer the company of those who have a compatible outlook and consider those who reject their optimism to be cynics. Although this outlook may sometimes lead to them being exploited by others, it tends to preclude catastrophic reactions to these events. In its more exaggerated forms, this presentation will often cease to signify positive attributes. Instead, it may mask a predisposition to delusional disorder or massive denial, such as is occasionally seen in la belle indifference with conversion disorder or anorexia nervosa. That is, there are psychopathologies associated with excessively high scores on the Cared for vs. Neglected scale. Although these elevated scores were absent from the current inpatient sample, clinical experience offers interpretive suggestions. The following are examples of conditions that may be present in persons with extremely high scores: delusional disorder with grandiose features and a sense of entitlement, histrionic denial and exaggeration, self-enhancement for the purpose of concealing character flaws. Persons who present themselves as incredibly cared for and loved thereby alert the examiner of the need to consider these and other possibilities. By definition, more modest elevations were seen in patients with average Cared for scores (T50-T64). Looking beyond this overall response level to their pattern of answer choices, they answered a mean of 65.9% of the scale's items in 1-keeping with the positive direction of the bidirectional key. Thus, scores typically fell well below the maximum possible by 34.1%. Their rate of positive answer choice endorsements compared with an average of 45.1% answered in a positive direction by those who felt neglected, as described later. Average scorers expressed considerably less mistrust, suspicion, and cynicism than did patients who felt neglected. They were less guarded interpersonally and did not have prominent ideas of reference. But, unlike those with very high scores, they did admit to viewing others' motives and intentions with some caution and justifiable suspicion at times. In these regards, they took a more balanced and realistic view of themselves. No patient scores exceeded T64.

The neglected.

When reminiscing about early life events, there are patients who feel neglected or treated as second rate or even actively disliked and rejected. Those scoring extremely low on this scale, for example, will recount childhood memories of deprivations, abuse, and other harsh treatment by their families. Feeling externally cut off or assaulted, these persons externalize blame for life's disappointments and troubles. They feel adrift in an uncaring world of people who, they believe, are devoid of human kindness or fellow feeling. Benjamin (1993) traced paranoid attitudes

to similar origins. Individuals view others as being energized and propelled by selfish motives to gain an advantage at their expense. Thus, they anticipate that others will conceal their intentions by dissimulation, even while they keep claiming that they are "trying to be helpful" or "to do what is best." Worse yet, they expect to experience loss or to be harmed at the hands of others. In keeping with their uncertainty about what others may be concocting, they relate to them in a wary, guarded manner as the only safe course of action. For some of these patients, the profound lack of confidence in the predictability of interpersonal relations primarily affects their reality testing. Hence, their suspicions can be painfully intense, engendering ideas of reference. Persons who they think have opposed or harmed them become objects of their fear, resentment, and sometimes hatred. In a kind of virtual reality, those persons become opponents or enemies. The neglected obsess about their perceived injuries and how to neutralize the harm or even scores. Their obsessing may lead them to seek retribution by making accusations, legal action, or overt physical harm. Yet, an item average (45.1%) suggested patients felt somewhat cared for.

Some of the neglected and disliked follow another course, dwelling in an abyss of hopelessness and dysphoria. Obtaining a detailed life history for such individuals will often reveal significant depression during childhood. It is a kind of depression that is markedly notable for the degree of anhedonia that is present. This will have been manifested during early childhood by rapidly shifting play interests and an inability to settle down to any one thing. The school record will confirm that the depressive process continued to affect their learning. It is further informative simply to ask these persons what they liked to do when they were children and what they liked about school. Their interests and sources of gratifying experience appear to have been severely constricted. Herein lies a puzzle. Why does one Neglected/Disliked patient externalize blame and adopt a counterattack mode while another retreats into resignation and despair? The source of these differences seems to be early temperamental dispositions that incline them along differing life courses. Thomas and Chess (1977) showed how active and passive forms of behavior disorders commence and persist from dispositions that are reliably seen in infancy. Uncovering the contribution of temperament to the expression of pathology adds to understanding the patient. The basic MMPI-2 Si scale and its cluster mates are useful in this regard. More importantly, knowing about this will suggest that the clinician use different therapeutic approaches with patients who present with actively versus passively expressed disorders.

Autonomous/Self-Possessed vs. Self-Doubting/Shamed

Autonomous.

Persons receiving highly Autonomous scores report that their families treat them as adults by respecting their individuality. They claim also that they and family members always function in positive ways with each other. They

see themselves as upright persons who maintain satisfactory selfcontrol across a variety of ordinary and stressful situations. They believe in accepting personal responsibility for their actions. These persons compare themselves favorably to others. They claim to be socially at ease, as well as to feel in balance, for the most part, both mentally or physically. Further, they state that they act decisively and are assertive in interpersonal contexts. They are tranquil and ready for what comes next. The qualities that they assert regarding themselves, if actually present, make them comparable in ways to a master of the martial arts who is also a master of self. In this manner, the grandiosity of feeling excessively cared for in the prior life stage can be reinforced by a grandiose sense of personal mastery or control. That is, excessive autonomous feeling can turn toward willful insistence on having one's own way. This leads to defending determinedly the decisions and choices one makes as being necessarily right and good. How could things be otherwise when the overly autonomous individual is the one making those choices! Thus, a surplus of self-assurance may manifest itself by rigid insistence that "My way is the right way" or by the unwavering demand, "Be reasonable and do what I say." Because the overly autonomous person is also convinced of being upright personally, there is the risk of inflexibility of conscience that often extends to the actions of others. These same excesses lead in some persons to an obsessive-compulsive rigidity directed toward the goal of keeping everything under personal control. For the foregoing reasons, moderately elevated scores on this scale are more likely to represent true positive attributes, whereas excessively high scores raise doubt concerning their accuracy. The average scoring patient answered a mean of 70.6% of the items in a positive direction, significantly below (29.4%) the maximum that might be claimed. Unlike those who might attain very high Autonomous scores, they admitted to having self-doubts and feelings of shame. Compared with the Doubting scale (see later), they reported less shyness, shame, and sensitivity to criticism. No patient scores exceeded T62 on this scale.

Doubting.

Persons scoring toward the low end of this scale report that their families have intruded into their personal affairs and left them conflicted over their status as adults. Often they are troubled by unfinished childhood business and entertain regressive fantasies. Their locuses of responsibility and control are decidedly external. They do not do; they are done to. Jealousy and strife within their families are commonplace. They view themselves as evil, damaged goods. This expresses itself in ongoing intropunitiveness that reinforces a core of shame. Affective presentation will confirm this impression. Psychologically, they may feel like lepers or pariahs. This makes them uncomfortable being in the limelight or at the center of attention. Being in such situations leaves them panicked that others are fully cognizant and contemptuous of their shameful state of being. They feel hatred toward those who expose them to shame or even those who witness their painful embarrassment. In order to escape from interpersonal situations where they feel outmatched, intimidated, or looked down on, many self-doubting persons submit readily to others' wishes. As a result, they may appear compliant and agreeable when in the immediate presence of those whom they view as their

betters. But, that impression is a misleading one. The reality is that they may be seething inside. Once out of hearing, they often express the passive-aggressive resentments that they have held in check while in the presence of those who impose on them. Some of the shamed frustrate the wishes of others by acting as if they do not understand or are incapable of doing what is asked of them. It will at times be suspected that—when they say they "forgot" what they were told to do, or when they have spoiled something they were asked to care for or failed to start a job on time—they in fact may have acted deliberately in order to discourage others from making further requests of them. Claiming incapacity or disability as a reason for failure is a more extreme version of the same (Dreikurs, 1957). Because the shame-oriented person feels indecisive, awkward, and profoundly self-doubting, it requires little self-deception to plead incapacity. Patients in this hospital sample's lowest scoring group, on average, did not provide self-attributions that were as negative as the preceding description. In fact, they answered a mean of 52.2% of the scale's MMPI-2 items in a positive direction, even though their standard scores (T35 and below) appeared extreme when compared to those of normals. Only 1.12% of patients had scores that were three standard deviations below the mean (T20 and below). This suggests that extremely low, as well as high, scores may be of questionable validity.

Initiating/Pursuing vs. Regretful/Guilt-Prone

Initiating.

The initiators have learned those skills of planning and anticipating that enable them to pursue goals actively while remaining within socially acceptable bounds. Being active and doing things are major goals and sources of satisfaction. The capacity to observe boundaries while thus engaged leaves them free, they say, from guilt, regrets, and the need to apologize. They have tried out a variety of roles and learned to fit into them and to own them. This process of role adoption has enlarged their capacity for appreciating others' viewpoints and understanding the reasons for them acting as they do. They, consequently, report that their interpersonal relations are guided by a sense of mutuality. Strong emotions and resentments are so well controlled that they do not disrupt relationships. Socially conforming behavior is the norm for them. These individuals so strongly identify with social norms that they respond automatically to test items, denying that they have violated or would ever violate behavior norms. Nevertheless, they may engage in egocentrically motivated pursuits without recognizing that they have strayed beyond the bounds of some norm until a misstep draws this to their attention. This occurs when they become greatly absorbed in their pursuits and regard their actions at the time in light of an immediately appealing goal. When an infraction is brought to their attention, they express surprise and assert that they did not know that they were doing wrong. These persons report having acceptable behavior during their school years and deny a history of antisocial

actions. Overall, they exhibit the conventional morality of obedience (Piaget, 1967) and respond to test items accordingly. They have abundant energy, enthusiasm, and curiosity, and they enjoy interpersonal competition. These forces together create their immense potential for pursuing whatever fascinates them. Herein also hides the danger of their focusing on pursuits of the moment. They fail at times to recognize that a boundary has been breached. Some adult antisocial behaviors that result in legal charges appear to begin innocently enough with energetic pursuits after one pleasure or another. All of this happens without apparent norm violating intent. Again, the following are typical reactions when initiators are brought to task: (a) "I'm sorry. I didn't think I was intoxicated." (b) "We were only playing around. I didn't mean to hurt anyone." (c) "I thought it was okay to go in there. There wasn't a sign or anything." The pattern of denial that asserts itself in extremely high scores that the Initiators receive on this scale again marks their behavior when they become ensnared in some misadventure. Patients with valid records received high scores 0.93% of the time, and no patients with invalid records had scores in this range. All of the elevated scores fell between T65 and T69, so none was extremely high. The genders were about evenly represented among high scorers. About one half of the group had various psychotic diagnoses, with the rest being of diverse classifications. Patients with scores of average elevation showed both more of a balance between acceptance of the norms and recognition of their personal shortcomings relative to them. They, for example, admitted to intrusive, egocentric actions that would not be acknowledged by those with extremely high Initiating scores. They also confessed more readily to feeling guilt about their indiscretions. They responded, on average, to MMPI-2 items at a rate below that of extreme Initiators (63.4% positive). On the other hand, they differed considerably from the low scorers who responded in more self-deprecating ways to items (only 45.3% positive). In particular, average scoring Initiators reported significantly less misbehavior as children and fewer antisocial behaviors and attitudes than did low scorers.

Guilt-Prone.

For persons receiving extremely low scores on this scale, life seems to abound with opportunities to engage in questionable, out of bounds, or frankly dangerous actions. They have taken part from childhood onward in a variety of norm violating behaviors. These include using other people. They participate in many of them with awareness of what they are doing rather than stumbling into them innocently. Knowing right from wrong does not deter them. Even though they are cognizant of the unacceptability of their actions, they continue to focus on immediate gratification to the exclusion of anticipating the consequences of their intrusive behaviors. They differ from the initiators in how they handle the aftermath of such events. Some dwell on their regrets. Others make excuses or lie in an effort to deflect blame onto someone else. Still others simply reject the consequences and react angrily toward those who catch them or express disapproval. Depending on the individual's emotional disposition, either anxiety develops when they must face consequences or wariness occurs in anticipation of reprisal from those whom they

have wronged. Those who react angrily to being caught engage in determinedly active forms of opposition. Those who do this turn with the passing years in ever more norm violating directions. These developments underlie antisocial behavior patterns from an early age wherein immediate rewards are sought by deviant actions. Some of the guilt-prone act in more passive-aggressive ways. Only 0.56% of the patients responded with extremely low scores (< 3 SDs). A somewhat higher rate reasonably may be expected among convicted felons.

Industrious/Capable vs. Inadequate/Inferior

Industrious.

High scorers on this scale find their lives interesting and engrossing. For some, their pattern of strong involvement in productive activities began in childhood in the guise of a favorable outlook on school and by way of their participation in extracurricular events and youth organizations. Others identified more with hands-on work and found ways to earn spending money or to help their families with chores. Their prior positive life accomplishments have resulted in exceptional confidence in their ability to succeed in the present and the future. Industrious persons' energy, attentional focus, and positive mood toward productive activity are associated with regular participation in employment. They express enjoyment in being busy. They persist in the face of adversity and proceed to do whatever needs to be done to finish a job. They derive from work the assurance that they are useful members of their community. This assurance that their contribution is valued is a source of both confidence and satisfaction. Overcommitment to productivity often means that individuals curtail social involvement and neglect family life and leisure. The workaholic pattern then eventuates in health risks, constriction of interpersonal ties, and emotional vulnerability to the effects of economic cycles on employment or advancement. Patients with average Industrious scores responded to 66.9% of items in this way. With their balanced outlook, they had reduced emphasis on success, energy resources, and personal capability. None of the patient sample scored above T58 on this scale. Compared to the Inadequate feeling (see later), they reported that they had more energy, were better able to work, expected to achieve greater success, and experienced greater enjoyment of life.

Inadequate.

As they were growing up, the Inadequate feeling found that they did not easily accommodate to school routines. Many concluded that formal learning was a pursuit for which they were ill equipped. Their memories of school days are remarkably negative, and they may defensively denigrate school as irrelevant. For others, the poor school experience has led to a palpable sense of personal inadequacy. Self-confidence is correspondingly impaired unless they have been so fortunate as to find alternative avenues to satisfaction in productive work. Even then, feelings of

dissatisfaction linger beneath an exterior of successful employment. The inadequate have low personal expectations for their success in new ventures, and they give up when they meet adversity. They consider so little of their abilities that they readily defer to others' opinions and leadership. Many have uneven employment records with frequent job changes, absenteeism, and substandard job performance despite apparently adequate ability. Fundamentally, they are disappointed with themselves and struggle with an abiding conviction that they are less capable than others. Compared with the preceding description of the inadequate, low scoring patients overall responded to items of this scale in less self-deprecating ways, with 51.4% of their responses being somewhat positive. A notable subgroup of them (6.52%), however, scored three or more standard deviations below the national norm (T20 or below). Among the six Psychosocial scales, Industrious vs. Inadequate produced the largest percentage of patients with extremely low scores. Using Erikson's (1963) terms, this subgroup's inferiority feelings are profound and rival those for mistrust, shame, and guilt.

Life-Goal Oriented/Ego Identity Secure vs. Directionless/Confused

Ego Identified.

High scorers claim that they firmly grasp attainable life goals. Even when confronted with life's many uncertainties, they have faith that they can reach out and take hold of a future that has meaning for them. These individuals actively pursue their goals through identification with a career path and the expression of their sexuality. Life outcomes are influenced, they believe, by their choices and actions. This perspective resembles what Maslow (1968) and others believed to be the essence of self-actualizing persons—an apparently uncommon breed and not expected to be present among these inpatients. Whereas family and friends are important to them, they distinguish and maintain their own boundaries. They regard themselves confidently, believing they are capable of handling whatever life sends in their direction. They, thus, exude an optimism about the future and their capacity to be ready for it. Among valid adult patient records none fell into the high scoring group (T65 and above). That is, no scores were extremely high, ranging well below T70. All the higher scores were produced by females. Interestingly, none of the records rejected as invalid scored above T60 on this scale. Patients whose scores were average responded to 70.2% of the items in a direction favorable to themselves. Unlike maximum scores, they admitted to being influenced by others more than they cared to be, not always being able to meet life's demands, and having some personal defects or deficiencies. Yet, as compared to low scorers, they experienced less conflict over career choice, were better able to plan their life course, felt greater positive self-regard, and could envision a future. Once again, the moderately

elevated scores are more credible unless those subjects being tested are recognizable as highly gifted persons or individuals who display a grandiose outlook.

Confused.

Low scorers cannot apprehend with any certainty a future for themselves. Choices and opportunities that come their way seem enigmatic, confusing, unclear, without meaning, and/or unattainable. Unbounded indecisiveness precludes planning and setting realistic goals.

Their career and sexual identities may remain murky and conflicted. When they attempt to resolve these ambiguities, they do so as persons whose fate is controlled by the external forces of family disagreement and pressure, what they believe to be unmanageable personal flaws, life's imponderables, and chance. These people feel put upon and harassed by life circumstances. They are ill at ease with themselves and may obsess over the burden that they have become for others. A distinctly defined ego identity eludes them. As a result, they must navigate life without compass or chart. Only 1.49% of patients in this sample scored three or more standard deviations (T20) below the normative mean for this scale. Extremely low scores seem likely to represent a form of intentional exaggeration of misery and feelings of inferiority more than a state of confusion.

Socially Committed/Involved vs. Disengaged/Lonely

Involved.

High scorers on this scale identify themselves as extremely engaged with other people. They enjoy their involvement and believe that other people reciprocate their positive feelings. They say that they mingle comfortably and easily in all social situations. Their sense of belonging socially is strong. They deny having interpersonal conflict with family and other intimates. Their view of married life is comparably idyllic. It corresponds to the idealized state referred to as marital bliss. These individuals claim that, for them, this is a continuous rather than a temporary or occasional condition. They report abundant affection, happiness, companionship, and satisfaction as being the norm for them. The involved practice exceptionally honest, open communication and are likely, they say, to tell others explicitly what they are thinking and feeling, even when this might prompt unpleasant feelings in others. In fact, they report no hesitancy about letting others know their innermost thoughts. They further affirm that they seek out opportunities to communicate with others rather than waiting for them to initiate conversation. This group's stated ways of relating to others may appeal to a few kindred spirits, however it likely conveys different impressions to

others. The incredibly open communication that they claim would often generate hurt feelings, interpersonal conflict, and a tendency for others to distance themselves from them. The force of their direct style may convey histrionic sensationalism, gross insensitivity, or possibly sadistic intent. It follows that their belief that nearly all people respond to them positively appears to be a serious misapprehension. Such a belief could only be sustained by denial or some other reality distorting strategy. Average scoring patients in the hospital sample answered a mean of 71.4% of this scale's items in this manner. None of the valid adult sample scored above T60 on the Involved vs. Disengaged scale. Compared with maximum possible scores, they typically did not claim that it was easy for them to converse with new acquaintances or to mingle at social gatherings. They further did not claim to reveal their inner thoughts and feelings as freely. They did, however, generally report that others liked them. Compared with the disengaged (see later), who answered only 48.8% of the items in the involved direction, the average scoring patients reported engaging in some open communication and relating more comfortably with others.

Disengaged.

The disengaged are those with fairly minimal scores on this scale. They present a pitiable picture of themselves as both socially isolated and painfully wishing not to be that way. Consequently, these individuals feel unlikable, bereft of companionship, and deeply lonely. It is difficult, if not impossible, for them to modify their situation inasmuch as they believe that they are not capable of making friends. They experience significant interpersonal conflicts with family and those few persons with whom they have tried to experience closeness. Comparable feelings permeate their perspective on romantic alliances and marriage. Their own bitterness about their affectional deprivation may appear in the form of cynical pronouncements that overgeneralize their personal frustration as if it were the condition of all people. They are exceedingly reticent about opening themselves up to scrutiny by others. Blocked and censored communications are the norm for them. They will go out of their way to avoid communicating with others. Their active avoidance keeps them disengaged. Moreover, they communicate by their nonverbal behavior that they have no desire to relate. This is not the case, but others reasonably conclude that they are disliked and are being avoided. The low rate for such powerful feelings of isolation can be judged from the fact that only 1.12% of valid adult patient records received scores as much as three standard deviations below the mean (T20) on the Involved vs. Disengaged scale. Markedly low scores, hence, are suspect as giving evidence of a disposition to fake bad. Such cases should be subjected to close examination.

PSYCHOSOCIAL SCALES, CONTENT CLUSTERS, AND AXIS I CONDITIONS

Studying DSM Axis I Linkages

Weak DSM-MMPI-2 Linkages. The construction of the DSM dichotomized categories is covered in chapter 5. Initial examination of relations among the diagnoses and MMPI-2 scales produced only a limited number of significant results. The diagnoses related with any consistency to MMPI-2 scales in a sparse number of content areas. Others have encountered similar challenges when seeking to find direct, clear-cut correspondences between psychiatric diagnoses and MMPI/MMPI-2 (Franklin, Strong, & Greene, 2002; Pancoast, Archer, & Gordon, 1988; Wetzler, Khadivi, & Moser, 1998).

Although it would have been useful to treat the diagnoses as one class of criterion variables, this was obviated except for a narrowly restricted set of findings. A similar conclusion was reached when the diagnoses were examined in relation to a smaller sample of Rorschach records ($n = 54$) that were coded using the Comprehensive System (Exner, 1993, 2000; Weiner, 1998). Then a third comparison was made of MMPI-2 scales and Rorschach codes in the same small sample. Once more, only a small number of significant findings emerged that were not systematically aligned with one another. Based on the foregoing, major emphasis is given in the analyses here to content clusters instead of psychiatric diagnoses. See Appendix D for more on DSM, and chapter 11 on Rorschach ties. For all analyses performed by the broad DSM-related content clusters in this chapter, the Psychosocial scale scores were partitioned into ranges based on departure from T50 by plus or minus 1.5 standard deviations. Scores in the midrange were further divided at T50. This resulted in the following classifications: Very low T35 and below, Low T36-49, Average T50-64, and High T65 and above. These groupings were stored as six categorical variables in which the following respective codes were assigned: 1, 2, 3, and 4. The inpatient cases who received high scores (Code 4) were either completely absent from the sample or there were too few of them to support separate analyses. On the other hand, those inpatients with very low scores were numerous enough to form groups for analyses.

Overall Level of Psychosocial Difficulties. A principal components factor analysis was performed for the 1,020 valid cases in order to examine the structure of the six Psychosocial scales in their standard score form. A single extracted factor accounted for 54.3% of the total variance. All of the scales correlated with the factor .65 to .83. The high unity of their structure meant they could be combined in various ways for the analyses that appear in this chapter.

Information from the six Psychosocial scales was combined for use in subsequent analyses as follows. First, a separate dichotomized variable was created for each of the six Psychosocial scales. In each variable, very low scores were identified by a code (7) and higher scores (i.e., 2, 3, and 4) by a different code (0). Second, the six scales were merged into a composite variable that represented an overall level of psychosocial difficulty reported by each patient. That is, if a patient reported a difficulty (Code 1) on only one of the scales, then a score of 7 was assigned and so on up to a maximum of six. AdjAll had identified 1,020 valid adult cases. Of these, 537 were valid cases of males and females combined who had reported a problem (i.e., had a very low score) on one or more of the scales and 483 valid

cases who had no ($n = 0$) identified psychosocial problems. The distribution of 537 cases formed a data pyramid: 6 difficulties identified ($n = 4$), 5 ($n = 26$), 4 ($n = 44$), 3 ($n = 87$), 2 ($n = 130$), and 1 ($n = 246$).

Data Configurations for Analysis. The foregoing patients were then assembled into two configurations suitable for data analysis. In the first configuration, patients having no identified psychosocial problems were compared with the aggregate of all those who identified one or more problems. These analyses compared the presence versus absence of psychosocial difficulties across the content clusters. In a second configuration, patients with a single psychosocial problem ($n = 246$) were compared with a combined grouping of patients who reported having three or more psychosocial problems ($n = 161$). These analyses explored the question of whether or not a larger loading of psychosocial difficulties results in greater problems in various Axis I areas that are represented by the content clusters.

Analyses of Presence vs. Absence of Difficulties

Thought Process Disorders.

A multiple regression analysis compared patients who reported psychosocial difficulties with those who did not report these. Because of many item overlaps among MMPI-2 scales that appear for the psychotic spectrum and other content clusters (i.e., many unavoidable linear dependencies are present), a preliminary analysis was performed of each content cluster as a means of identifying and selecting for a final analysis only those scales that appeared to contain somewhat independent pools of variance. Predictor variables entered into this preliminary solution were Sc, Sc[^]-corrected (ScK), BIZ, I-RD, 8BSE, W-PSY, I-DS, Pa, S+, and 6PI. For ease of reference, a listing of all abbreviated scale names appears after the Preface. Five of the scales survived preliminary inspection and were entered into an actual regression equation. It produced a multiple R of .65, accounting for 42.47% of the variance, $F(5, 1014) = 149.70$, $p < .0000$. Betas were assigned to these surviving, statistically significant variables: Sc (1.02), ScK (-.35), 8BSE (-.17), S+ (.08), and 6P (-.10). Patients with no reported psychosocial difficulties had means on the predictors ranging from T47.75 (Sc) to T53.86 (6PI). Those reporting psychosocial difficulties had predictor means ranging from T59.05 (ScK) to T62.28 (6/Y). Thus, the groups differed by about one standard deviation for this content cluster. The conjoint functioning of Sc and ScK are notable findings, and incremental contributions

appeared for other variables. The contribution of Sc to the solution, in effect, is moderated by the corrected ScK when both versions of the scale are used, and the resulting R is greater than when only one of the versions is used.

Depressive Spectrum Conditions.

The preliminary list of scales for depressive conditions included: D, TSC/D, DEP, W-DEP, 2SD, 2B, 2PR, 3LM, SEA, and D-S. Although all of the scales reliably separated the two groups, the preliminary equation quickly eliminated duplication and narrowed the list to two scales. The equation that resulted from entering them accounted for 44.15% of the variance ($R = .66$) and produced $F(2, 1017) = 402.05$, $p < .0000$. The two surviving scales both contributed at highly reliable levels to the solution with the following assigned betas: TSC/D (.58) and D-S (-.17). Means for the psychosocial difficulties group and no difficulties were, respectively: TSC/D T65.56 and T48.51; D-S T45.83 and T54.51. The differences between the means for two nonselected scales, for example, D and DEP were T10.75 and T15.05, respectively, compared with TSC/D's T 17.05 difference.

Anxiety Spectrum Conditions.

The content cluster scales—Pt, PtKcorrected (PtK), TSC/T, ANX, Panic, A, PK, PS, and 4SA—were evaluated in a preliminary analysis. This led to a final selection of four predictors. A multiple R (.69) found by the regression solution explained 48.25% of the variance, $F(4, 1015) = 236.57$, $p < .0000$. Each of the four predictors contributed significantly to the solution, resulting in the following betas: Pt (.39), PtK (-.10), 4SA (.15), A (.27). Scale means for the no psychosocial difficulties group ranged from T46.50 (Pt) to T53.37 (4SA) and for the group with difficulties from T61.24 (PtK) to T68.64 (4SA). All differences between the groups exceeded one standard deviation. It is notable to observe again the conjoint functioning of a clinical scale in its uncorrected (Pt) and corrected (PtK) forms. The placement of 4SA in the anxiety cluster was also strongly supported.

Obsessions and Phobias.

The four scales—OBS, I-OC, FRS, and WPHO—are parts of the anxiety cluster but were singled out for separate analysis because they are treated separately in the DSM series. I-OC, whose original value has been absorbed by OBS, was not included in the prediction equation. The three scales that were entered each contributed reliably and together produced a multiple[^] of .56 for a multiple R squared variance of .31 and $F(3, 1016) = 154.75$, $p < .0000$. Betas associated with each scale were: OBS (.49), FRS (-.18), and W-PHO (.27). Means on these scales for the difficulties

versus no difficulties groups were, respectively: OBS T59.38 and T46.79, FRS T56.09 and T50.82, and W-PHO T56.39 and T49.41.

Cognitive Disorders.

These disorders were clearly differentiated from intellect by first comparing the two psychosocial groups' IQ scores. The groups differed on none of the three indexes (Verbal, Performance, Full Scale). Scales checked in a preliminary analysis of this cluster were: 2MD, 8COG, TSC/A, 8BSE, NeurPsy, W-ORG, I-DS, and Inconsistency (RConPr). Four scales were kept in the final analysis. The regression solution yielded a multiple R of .66 that equated to 43.71% of the variance and resulted in $F(4, 1015) = 197.02, p < .0000$. Each of the following scales reliably entered the solution, with the following betas: 2MD (.44), 8COG (-.13), TSC/A (.33), and RConPr (.14). Means of the no difficulties group ranged from T44.86 (RConPr) to T47.91 (8COG). Those for the difficulties group went from T55.74 (RConPr) to T63.80 (2MD).

Somatic Concerns.

This cluster provided nine scales for preliminary inspection: Hs, //^corrected (HsK), HEA, TSC/B, W-HEA, 2PM, 3SC, TPA, and Ho. Five of these were retained by regression analysis. A multiple R of .60 explained about 36% of the variance. The betas attached to the successful predictors were: Hs (.71), HsK(-.60), HEA (.20), TSC/B (.28), 2PM(.10), Ho (.13), and TPA (.10). The overall prediction equation produced an $F(7, 1012) = 80.78, p < .0000$. Means for the difficulties group ranged from a low of T56.66 (TPA) to T61.98 (2PM) and for no difficulties from T45.14 (TPA) to T54.24 (2PM). The two groups differed greatly on all scales in the cluster, and the listed four were found to operate more independently of others. The Hs and HsK forms complemented one another, and other scales added validly to the solution. Contributions of Ho and TPA are in keeping with prior research (see chap. 4).

Stimulus Seeking and Drive. The scales in the short list for this cluster have some bearing on bipolar disorders in addition to their characterological implications. The preliminary list consisted of Ma, MaK-corrected (MaK), W-HYP, 9PMA, 9EI, and 2PR. The three successful entries had the following betas: Ma (1.52), MaK (-1.42), and 2PR (.37). The amount of variance determined by these three was 37.42%, $R = .61, F(3, 1016) = 202.47, p < .0000$. Means for the no difficulties versus difficulties groups, respectively, were T50.34 and T56.17 (Ma), T51.30 and T54.95 (MaK), and T44.15 and T60.22 (2PR). The complementarity of Ma and MaK in the prediction of psychosocial difficulties is noted.

Substance Dependency.

The Critical Inquiry Addictive Activities (AA) scale was not employed in this analysis because it could only be scored fully in MMPI-2. Two MMPI-2 scales for predicting chemical dependency are included in the Behavior Controls cluster but are treated separately here in order to fit the DSM Axis I category. These are MAC-R and APS. Surprisingly, the more popular of these scales barely differentiated the two groups, with the mean for MAC-R being T61.26 in the psychosocial difficulties group and T59.31 for the no difficulties group ($t = 2.59$, $df = 1018$, $p < .01$). With APS as the solitary scale left, groups were compared by t test rather than regression. Whereas APS differentiated the groups ($t = 10.18$, $df = 1018$, $p < .0000$), the means were unexpectedly low: no difficulties (T45.16) and psychosocial difficulties (T52.83). The low means for APS did not result from the MMPI-to-MMPI-2 score estimation process. This was verified by a finding of comparably low scores in the MMPI-2 sample that was scored directly without resorting to estimation. In view of the known high rate of substance abuse in this sample, these very average mean values are difficult to interpret or reconcile. Thus MAC-R and APS were not useful for identifying both group differences and their actual levels of substance dependency. Nevertheless, based on substantial evidence of the MAC-R's value relative to a variety of the chemical dependencies (Lachar, Berman, Grisell, & Schoof, 1976; Levitt & Gotts, 1995), it is retained as a core scale in the database.

Analyses of Differing Psychosocial Difficulty Levels

The analyses reported in this section are based on the second data configuration. In these, valid adult patients who reported a single psychosocial difficulty ($n = 246$) are compared to those who reported three or more ($n = 161$). As in the preceding analyses, preliminary checks were made of all scales in each cluster, after which final regression analyses were performed. The reports omit the preliminary listing and all begin with the final regression analysis.

Thought Process Disorders.

Six scales entered the final analysis. The multiple R was .72 and total variance explained was 52.14%. All six of the final scales related significantly to the criterion. Their betas were: Sc (.86), ScK (-.35), BIZ (-.29), 8BSE (-.17), W-PSY (.30), and S+ (.21). The overall solution was highly significant: $F(6,400) = 72.62$, $p < .0000$. The means for one versus multiple psychosocial difficulties ranged from T53.30 (S+) to T56.87 (8BSE) for the former and from T64.20 (ScK) to 69.54 (Sc) for the latter. All differences between the two groups were around one standard deviation. The two groups differed on all of the variables in the content cluster.

Depressive Spectrum Conditions.

The solution for this equation used four scales, with the following betas: TSC/D (.17), W-DEP (.32), 2PR (.13), and D-S (-.38). All were significant. The multiple R was .67 for a variance total of 44.74%: $F(4, 402) = 81.37, p < .0000$. Means for those with a single difficulty were TSC/D T59.74, W-DEP T59.26, 2PR T53.69, and D-S T49.10. The corresponding means for those with multiple difficulties were: T73.96, T72.84, T56.01, and T40.41. Whereas all of the variables in the depressive cluster reliably differentiated between the groups, only those in the equation were sources of more independent variation.

Anxiety Spectrum Conditions. A large multiple R (.70) resulted from the solution to this equation: $F(5, 401) = 79.18, p < .0000$. The solution expressed 49.68% of the variance. These were the scales that reliably remained in the regression equation plus their respective betas: PtK (-.12), TSC/T(26), ANX(-A4), A (.49), and PK (.44). Means for one difficulty ranged from T57.12 (A) to T59.26 (ANX); those for multiple difficulties went from T65.38 (PtK) to T72.67 (PK).

Obsessions and Phobias. A smaller amount of variance was captured by the scales in this part of the anxiety cluster (29.26%) based on a multiple R of .54. The result, nevertheless, was highly reliable: $F(3, 403) = 55.56, p < .0000$. The 7 OC scale's share of variance was totally provided by OBS (beta .42). Two other reliable scales and their shares were: FRS (-.21) and W-PHO (.38). Means of the two groups were all clearly spaced apart from each other: One difficulty versus multiple difficulties (OBS T55.50 vs. T65.65; FRS T53.25 vs. T60.03; W-PHO T53.08 vs. T60.03).

Cognitive Disorders. IQs were again checked and no differences were present between the two groups. Only two scales reliably distinguished the groups from one another: 2MD (beta .19), whose means were for one difficulty T59.34 and for multiple difficulties T69.13; and TSC/A (beta .48), whose means were for one difficulty T53.17 and for multiple difficulties T64.85. The two groups differed: $F(2, 404) = 97.89, p < .0000, R = .57, R^2 = .33$.

Somatic Concerns. The scales Hs (beta .73), HsK (beta -.69), HEA (beta -.36), TSCIB (beta .41), and //o (beta .37) together predicted 37.40% of the difference between the two groups ($R = .61$). Their respective means for one and multiple difficulty groups were: Hs T58.24 and T62.65; HsKT56.Q6 and T54.93; HEA T57.73 and T62.13; TSC/B T57.77 and T63.53; and Ho T54.40 and T67.94. The overall result was significant: $F(5, 401) = 47.91, p < .0000$.

Stimulus Seeking and Drive. Four scales from this content cluster contributed to predicting the psychosocial score. They and their betas were: Ma (1.96), MaK (-1.88), 2PR (.31), and 9EI(. 17). Note that 9EI, which fits here, was not a reliable indicator of the difference reported earlier between the no difficulties group and those who reported having psychosocial difficulties. The present solution produced a multiple R of .62 and a matching variance of 39.02%, with

an $F(4, 402) = 64.3, p < .0000$. The single psychosocial difficulty group was contrasted with the multiple difficulties group, revealing the following means, respectively: Ma T54.11 vs. T60.45; MaK T53.58 vs. T58.19; 2PR T54.73 vs. T68.11; and 9EI T52.57 vs. T61.45.

Substance Dependency. In the final comparison of this configuration, once again, MAC-R failed to aid in prediction of psychosocial difficulties. At the same time, APS offered a low efficiency prediction ($t = 2.81, df = 405, p < .01$). The means of the two groups for APS, however, were out of line with the known high incidence of substance dependency in the hospital sample. Thus, neither of the scales offered a reliable means of estimating levels of psychosocial difficulties.

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Scale Composition

Validity and Clinical Scales

Validity and Clinical Scale composition:

Appendix A. Composition of Standard Validity and Clinical Scales

<i>L Scale</i>	47, 58, 76, 81, 91, 95, 98, 110, 115, 116, 124, 125, 129, 135, 141, 148, 151, 152, 157, 159, 161, 164, 167, 173, 176, 179, 185, 193, 208, 213, 224, 241, 243, 249, 253, 263, 265
True: NONE	
False: 16, 29, 41, 51, 77, 93, 102, 107, 123, 139, 153, 183, 203, 232, 260	
<i>F Scale</i>	
True: 18, 24, 30, 36, 42, 48, 54, 60, 66, 72, 84, 96, 114, 138, 144, 150, 156, 162, 168, 180, 198, 216, 228, 234, 240, 246, 252, 258, 264, 270, 282, 288, 294, 300, 306, 312, 324, 336, 349, 355, 361	<i>Scale 4—Psychopathic Deviate (Pd)</i>
False: 6, 12, 78, 90, 102, 108, 120, 126, 132, 174, 186, 192, 204, 210, 222, 276, 318, 330, 343	True: 17, 21, 22, 31, 32, 35, 42, 52, 54, 56, 71, 82, 89, 94, 99, 105, 113, 195, 202, 219, 225, 259, 264, 288
<i>K Scale</i>	False: 9, 12, 34, 70, 79, 83, 95, 122, 125, 129, 143, 157, 158, 160, 167, 171, 185, 209, 214, 217, 226, 243, 261, 263, 266, 267
True: 83	<i>Scale 5—Masculinity-Femininity (Mf)—Male</i>
False: 29, 37, 58, 76, 110, 116, 122, 127, 130, 136, 148, 157, 158, 167, 171, 196, 213, 243, 267, 284, 290, 330, 338, 339, 341, 346, 348, 356, 365	True: 4, 25, 62, 64, 67, 74, 80, 112, 119, 122, 128, 137, 166, 177, 187, 191, 196, 205, 209, 219, 236, 251, 256, 268, 271
<i>Scale 1—Hypochondriasis (Hs)</i>	False: 1, 19, 26, 27, 63, 68, 69, 76, 86, 103, 104, 107, 120, 121, 132, 133, 163, 184, 193, 194, 197, 199, 201, 207, 231, 235, 237, 239, 254, 257, 272
True: 18, 28, 39, 53, 59, 97, 101, 111, 149, 175, 247	<i>Scale 5—Masculinity-Femininity (Mf)—Female</i>
False: 2, 3, 8, 10, 20, 45, 47, 57, 91, 117, 141, 143, 152, 164, 173, 176, 179, 208, 224, 249, 255	True: 4, 25, 62, 64, 67, 74, 80, 112, 119, 121, 122, 128, 137, 177, 187, 191, 196, 205, 219, 236, 251, 256, 271
<i>Scale 2—Depression (D)</i>	False: 1, 19, 26, 27, 63, 68, 69, 76, 86, 103, 104, 107, 120, 132, 133, 163, 166, 184, 193, 194, 197, 199, 201, 207, 209, 231, 235, 237, 239, 254, 257, 268, 272
True: 5, 15, 18, 31, 38, 39, 46, 56, 73, 92, 117, 127, 130, 146, 147, 170, 175, 181, 215, 233	<i>Scale 6—Paranoia (Pa)</i>
False: 2, 9, 10, 20, 29, 33, 37, 43, 45, 49, 55, 68, 75, 76, 95, 109, 118, 134, 140, 141, 142, 143, 148, 165, 178, 188, 189, 212, 221, 223, 226, 238, 245, 248, 260, 267, 330	True: 16, 17, 22, 23, 24, 42, 99, 113, 138, 144, 145, 146, 162, 234, 259, 271, 277, 285, 305, 307, 333, 334, 336, 355, 361
<i>Scale 3—Hysteria (Hy)</i>	False: 81, 95, 98, 100, 104, 110, 244,
True: 11, 18, 31, 39, 40, 44, 65, 101, 166, 172, 175, 218, 230	
False: 2, 3, 7, 8, 9, 10, 14, 26, 29, 45,	

Source: Minnesota Multiphasic Personality Inventory-2 (MMPI-2): Manual for administration and scoring. S. R. Hathaway & J. C. McKinley with J. N. Butcher, W. G. Dahlstrom, J. R. Graham, A. Tellegen, & B. Kaemmer. Minneapolis: The University of Minnesota Press. Reproduced by permission.

255, 266, 283, 284, 286, 297, 314, 315	<i>Scale 9—Hypomania (Ma)</i>
<i>Scale 7—Psychasthenia (Pt)</i>	True: 13, 15, 21, 23, 50, 55, 61, 85, 87, 98, 113, 122, 131, 145, 155, 168, 169, 182, 190, 200, 205, 206, 211, 212, 218, 220, 227, 229, 238, 242, 244, 248, 250, 253, 269
True: 11, 16, 23, 31, 38, 56, 65, 73, 82, 89, 94, 130, 147, 170, 175, 196, 218, 242, 273, 275, 277, 285, 289, 301, 302, 304, 308, 309, 310, 313, 316, 317, 320, 325, 326, 327, 328, 329, 331	False: 88, 93, 100, 106, 107, 136, 154, 158, 167, 243, 263
False: 3, 9, 33, 109, 140, 165, 174, 293, 321	<i>Scale 0—Social Introversion (Si)</i>
<i>Scale 8—Schizophrenia (Sc)</i>	True: 31, 56, 70, 100, 104, 110, 127, 135, 158, 161, 167, 185, 215, 243, 251, 265, 275, 284, 289, 296, 302, 308, 326, 337, 338, 347, 348, 351, 352, 357, 364, 367, 368, 369
True: 16, 17, 21, 22, 23, 31, 32, 35, 38, 42, 44, 46, 48, 65, 85, 92, 138, 145, 147, 166, 168, 170, 180, 182, 190, 218, 221, 229, 233, 234, 242, 247, 252, 256, 268, 273, 274, 277, 279, 281, 287, 291, 292, 296, 298, 299, 303, 307, 311, 316, 319, 320, 322, 323, 325, 329, 332, 333, 355	False: 25, 32, 49, 79, 86, 106, 112, 131, 181, 189, 207, 209, 231, 237, 255, 262, 267, 280, 321, 328, 335, 340, 342, 344, 345, 350, 353, 354, 358, 359, 360, 362, 363, 366, 370
False: 6, 9, 12, 34, 90, 91, 106, 165, 177, 179, 192, 210, 255, 276, 278, 280, 290, 295, 343	

Appendix F. Composition of Si Subscales

Si1 (Shyness/Self-Consciousness)

True: 158, 161, 167, 185, 243, 265, 275, 289

False: 49, 262, 280, 321, 342, 360

Si2 (Social Avoidance)

True: 337, 367

False: 86, 340, 353, 359, 363, 370

Si3 (Self/Other Alienation)

True: 31, 56, 104, 110, 135, 284, 302, 308, 326, 328, 338, 347, 348, 358, 364, 368, 369

False: None

Source: Minnesota Multiphasic Personality Inventory-2 (MMPI-2): Manual for administration and scoring. (1989). S. R. Hathaway & J. C. McKinley with J. N. Butcher, W. G. Dahlstrom, J. R. Graham, A. Tellegen, & B. Kaemmer. Minneapolis: The University of Minnesota Press. Reproduced by permission.

Appendix H. Composition of Content Scales

ANX—Anxiety	False: 564
True: 15, 30, 31, 39, 170, 196, 273, 290, 299, 301, 305, 339, 408, 415, 463, 469, 509, 556	CYN—Cynicism
False: 140, 208, 223, 405, 496	True: 50, 58, 76, 81, 104, 110, 124, 225, 241, 254, 283, 284, 286, 315, 346, 352, 358, 374, 399, 403, 445, 470, 538
FRS—Fears	False: None
True: 154, 317, 322, 329, 334, 392, 395, 397, 435, 438, 441, 447, 458, 468, 471, 555	ASP—Antisocial Practices
False: 115, 163, 186, 385, 401, 453, 462	True: 26, 35, 66, 81, 84, 104, 105, 110, 123, 227, 240, 248, 250, 254, 269, 283, 284, 374, 412, 418, 419
OBS—Obsessiveness	False: 266
True: 55, 87, 135, 196, 309, 313, 327, 328, 394, 442, 482, 491, 497, 509, 547, 553	TPA—Type A
False: None	True: 27, 136, 151, 212, 302, 358, 414, 419, 420, 423, 430, 437, 507, 510, 523, 531, 535, 541, 545
DEP—Depression	False: None
True: 38, 52, 56, 65, 71, 82, 92, 130, 146, 215, 234, 246, 277, 303, 306, 331, 377, 399, 400, 411, 454, 506, 512, 516, 520, 539, 546, 554	LSE—Low Self-esteem
False: 3, 9, 75, 95, 388	True: 70, 73, 130, 235, 326, 369, 376, 380, 411, 421, 450, 457, 475, 476, 483, 485, 503, 504, 519, 526, 562
HEA—Health Concerns	False: 61, 78, 109
True: 11, 18, 28, 36, 40, 44, 53, 59, 97, 101, 111, 149, 175, 247	SOD—Social Discomfort
False: 20, 33, 45, 47, 57, 91, 117, 118, 141, 142, 159, 164, 176, 179, 181, 194, 204, 224, 249, 255, 295, 404	True: 46, 158, 167, 185, 265, 275, 281, 337, 349, 367, 479, 480, 515
BIZ—Bizarre Mentation	False: 49, 86, 262, 280, 321, 340, 353, 359, 360, 363, 370
True: 24, 32, 60, 96, 138, 162, 198, 228, 259, 298, 311, 316, 319, 333, 336, 355, 361, 466, 490, 508, 543, 551	FAM—Family Problems
False: 427	True: 21, 54, 145, 190, 195, 205, 256, 292, 300, 323, 378, 379, 382, 413, 449, 478, 543, 550, 563, 567
ANG—Anger	False: 83, 125, 217, 383, 455
True: 29, 37, 116, 134, 302, 389, 410, 414, 430, 461, 486, 513, 540, 542, 548	WRK—Work Interference
	True: 15, 17, 31, 54, 73, 98, 135, 233, 243, 299, 302, 339, 364, 368,

Source: Minnesota Multiphasic Personality Inventory-2 (MMPI-2): Manual for administration and scoring. S. R. Hathaway and J. C. McKinley with J. N. Butcher, W. G. Dahlstrom, J. R. Graham, A. Tellegen, & B. Kaemmer. Minneapolis: The University of Minnesota Press. Reproduced by permission.

394, 409, 428, 445, 464, 491, True: 22, 92, 274, 306, 364, 368, 373,
505, 509, 517, 525, 545, 554, 375, 376, 377, 391, 399, 482,
559, 566 488, 491, 495, 497, 499, 500,
False: 10, 108, 318, 521, 561 504, 528, 539, 554
TRT—Negative Treatment Indicators False: 493, 494, 501

Appendix J. Critical Item Lists

KOSS-BUTCHER CRITICAL ITEMS

Acute Anxiety State

- 2. I have a good appetite. (F)
- 3. I wake up fresh and rested most mornings. (F)
- 5. I am easily awakened by noise. (T)
- 10. I am about as able to work as I ever was. (F)
- 15. I work under a great deal of tension. (T)
- 28. I am bothered by an upset stomach several times a week. (T)
- 39. My sleep is fitful and disturbed. (T)
- 59. I am troubled by discomfort in the pit of my stomach every few days or oftener. (T)
- 140. Most nights I go to sleep without thoughts or ideas bothering me. (F)
- 172. I frequently notice my hand shakes when I try to do something. (T)
- 208. I hardly ever notice my heart pounding and I am seldom short of breath. (F)
- 218. I have periods of such great restlessness that I cannot sit long in a chair. (T)
- 223. I believe I am no more nervous than most others. (F)
- 301. I feel anxiety about something or someone almost all the time. (T)
- 444. I am a high-strung person. (T)
- 463. Several times a week I feel as if something dreadful is about to happen. (T)
- 469. I sometimes feel that I am about to go to pieces. (T)

Depressed Suicidal Ideation

- 9. My daily life is full of things that keep me interested. (F)
- 38. I have had periods of days, weeks, or months when I couldn't take

care of things because I couldn't "get going". (T)

- 65. Most of the time I feel blue. (T)
- 71. These days I find it hard not to give up hope of amounting to something. (T)
- 75. I usually feel that life is worthwhile. (F)
- 92. I don't seem to care what happens to me. (T)
- 95. I am happy most of the time. (F)
- 130. I certainly feel useless at times. (T)
- 146. I cry easily. (T)
- 215. I brood a great deal. (T)
- 233. I have difficulty in starting to do things. (T)
- 273. Life is a strain for me much of the time. (T)
- 303. Most of the time I wish I were dead. (T)
- 306. No one cares much what happens to you. (T)
- 388. I very seldom have spells of the blues. (F)
- 411. At times I think I am no good at all. (T)
- 454. The future seems hopeless to me. (T)
- 485. I often feel that I'm not as good as other people. (T)
- 506. I have recently considered killing myself. (T)
- 518. I have made lots of bad mistakes in my life. (T)
- 520. Lately I have thought a lot about killing myself. (T)
- 524. No one knows it but I have tried to kill myself. (T)

Threatened Assault

- 37. At times I feel like smashing things. (T)
- 85. At times I have a strong urge to do

something harmful or shocking.
(T)

134. At times I feel like picking a fist
fight with someone. (T)

213. I get mad easily and then get over it
soon. (T)

389. I am often said to be hotheaded.
(T)

Situational Stress Due to Alcoholism

125. I believe that my home life is as
pleasant as that of most people I
know. (F)

264. I have used alcohol excessively. (T)

487. I have enjoyed using marijuana. (T)

489. I have a drug or alcohol problem.
(T)

502. I have some habits that are really
harmful. (T)

511. Once a week or more I get high or
drunk. (T)

518. I have made lots of bad mistakes in
my life. (T)

Mental Confusion

24. Evil spirits possess me at times. (T)

31. I find it hard to keep my mind on a
task or job. (T)

32. I have had very peculiar and
strange experiences. (T)

72. My soul sometimes leaves my body.
(T)

96. I see things or animals or people
around me that others do not see.
(T)

180. There is something wrong with my
mind. (T)

198. I often hear voices without know-
ing where they come from. (T)

299. I cannot keep my mind on one
thing. (T)

311. I often feel as if things are not real.
(T)

316. I have strange and peculiar
thoughts. (T)

325. I have more trouble concentrating
than others seem to have. (T)

Persecutory Ideas

17. I am sure I get a raw deal from life.
(T)

42. If people had not had it in for me, I
would have been much more suc-
cessful. (T)

99. Someone has it in for me. (T)

124. I often wonder what hidden reason
another person may have for doing
something nice for me. (T)

138. I believe I am being plotted
against. (T)

144. I believe I am being followed. (T)

145. I feel that I have often been
punished without cause. (T)

162. Someone has been trying to poison
me. (T)

216. Someone has been trying to rob
me. (T)

228. There are persons who are trying
to steal my thoughts and ideas. (T)

241. It is safer to trust nobody. (T)

251. I have often felt that strangers were
looking at me critically. (T)

259. I am sure I am being talked about.
(T)

314. I have no enemies who really wish
to harm me. (F)

333. People say insulting and vulgar
things about me. (T)

361. Someone has been trying to influ-
ence my mind. (T)

LACHAR-WROBEL CRITICAL ITEMS

Anxiety and Tension

15. I work under a great deal of ten-
sion. (T)

17. I am sure I get a raw deal from life.
(T)

172. I frequently notice my hand shakes
when I try to do something. (T)

218. I have periods of such great re-
stlessness that I cannot sit long in a
chair. (T)

Appendix J (*continued*)

223. I believe I am no more nervous than most others. (F)
 261. I have very few fears compared to my friends. (F)
 299. I cannot keep my mind on one thing. (T)
 301. I feel anxiety about something or someone almost all the time. (T)
 320. I have been afraid of things or people that I knew could not hurt me. (T)
 405. I am usually calm and not easily upset. (F)
 463. Several times a week I feel as if something dreadful is about to happen. (T)

Depression and Worry

2. I have a good appetite. (F)
 3. I wake up fresh and rested most mornings. (F)
 10. I am about as able to work as I ever was. (F)
 63. Most of the time I feel blue. (T)
 73. I am certainly lacking in self-confidence. (T)
 75. I usually feel that life is worthwhile. (F)
 130. I certainly feel useless at times. (T)
 150. Sometimes I feel as if I must injure either myself or someone else. (T)
 165. My memory seems to be all right. (F)
 180. There is something wrong with my mind. (T)
 273. Life is a strain for me much of the time. (T)
 303. Most of the time I wish I were dead. (T)
 339. I have sometimes felt that difficulties were piling up so high that I could not overcome them. (T)
 411. At times I think I am no good at all. (T)

415. I worry quite a bit over possible misfortunes. (T)
 454. The future seems hopeless to me. (T)

Sleep Disturbance

5. I am easily awakened by noise. (T)
 30. I have nightmares every few nights. (T)
 39. My sleep is fitful and disturbed. (T)
 140. Most nights I go to sleep without thoughts or ideas bothering me. (F)
 328. Sometimes some unimportant thought will run through my mind and bother me for days. (T)
 471. I have often been frightened in the middle of the night. (T)

Deviant Beliefs

42. If people had not had it in for me I would have been much more successful. (T)
 99. Someone has it in for me. (T)
 106. My speech is the same as always (not faster or slower, no slurring or hoarseness). (F)
 138. I believe I am being plotted against. (T)
 144. I believe I am being followed. (T)
 162. Someone has been trying to poison me. (T)
 216. Someone has been trying to rob me. (T)
 228. There are persons who are trying to steal my thoughts and ideas. (T)
 259. I am sure I am being talked about. (T)
 314. I have no enemies who really wish to harm me. (F)
 333. People say insulting and vulgar things about me. (T)
 336. Someone has control over my mind. (T)

- 355. At one or more times in my life I felt that someone was making me do things by hypnotizing me. (T)
- 361. Someone has been trying to influence my mind. (T)
- 466. Sometimes I am sure that other people can tell what I am thinking. (T)

Deviant Thinking and Experiences

- 32. I have had very peculiar and strange experiences. (T)
- 60. When I am with people, I am bothered by hearing very strange things. (T)
- 96. I see things or animals or people around me that others do not see. (T)
- 122. At times my thoughts have raced ahead faster than I could speak them. (T)
- 198. I often hear voices without knowing where they come from. (T)
- 298. Peculiar odors come to me at times. (T)
- 307. At times I hear so well it bothers me. (T)
- 316. I have strange and peculiar thoughts. (T)
- 319. I hear strange things when I am alone. (T)
- 427. I have never seen a vision. (F)

Substance Abuse

- 168. I have had periods in which I carried on activities without knowing later what I had been doing. (T)
- 264. I have used alcohol excessively. (T)
- 429. Except by doctor's orders I never take drugs or sleeping pills. (F)

Antisocial Attitude

- 27. When people do me a wrong, I feel I should pay them back if I can, just for the principle of the thing. (T)
- 35. Sometimes when I was young I stole things. (T)

- 84. I was suspended from school one or more times for bad behavior. (T)
- 105. In school I was sometimes sent to the principal for bad behavior. (T)
- 227. I don't blame people for trying to grab everything they can get in this world. (T)
- 240. At times it has been impossible for me to keep from stealing or shoplifting something. (T)
- 254. Most people make friends because friends are likely to be useful to them. (T)
- 266. I have never been in trouble with the law. (F)
- 324. I can easily make other people afraid of me, and sometimes do for the fun of it. (T)

Family Conflict

- 21. At times I have very much wanted to leave home. (T)
- 83. I have very few quarrels with members of my family. (F)
- 125. I believe that my home life is as pleasant as that of most people I know. (F)
- 288. My parents and family find more fault with me than they should. (T)

Problematic Anger

- 85. At times I have a strong urge to do something harmful or shocking. (T)
- 134. At times I feel like picking a fist fight with someone. (T)
- 213. I get mad easily and then get over it soon. (T)
- 389. I am often said to be hotheaded. (T)

Sexual Concern and Deviation

- 12. My sex life is satisfactory. (F)
- 34. I have never been in trouble because of my sex behavior. (F)
- 62. I have often wished I were a girl. (or if you are a girl) I have never been sorry that I am a girl. (T/F)

Appendix J (continued)

- 121. I have never indulged in any unusual sex practices. (F)
- 166. I am worried about sex. (T)
- 268. I wish I were not bothered by thoughts about sex. (T)

Somatic Symptoms

- 18. I am troubled by attacks of nausea and vomiting. (T)
- 28. I am bothered by an upset stomach several times a week. (T)
- 33. I seldom worry about my health. (F)
- 40. Much of the time my head seems to hurt all over. (T)
- 44. Once a week or oftener I suddenly feel hot all over, for no real reason. (T)
- 47. I am almost never bothered by pains over my heart or in my chest. (F)
- 53. Parts of my body often have feelings like burning, tingling, crawling, or like "going to sleep". (T)
- 57. I hardly ever feel pain in the back of my neck. (F)
- 59. I am troubled by discomfort in the pit of my stomach every few days or oftener. (T)
- 101. Often I feel as if there is a tight band around my head. (T)
- 111. I have a great deal of stomach trouble. (T)
- 142. I have never had a fit or convulsion. (F)
- 159. I have never had a fainting spell. (F)
- 164. I seldom or never have dizzy spells. (F)
- 175. I feel weak all over much of the time. (T)
- 176. I have very few headaches. (F)
- 182. I have had attacks in which I could not control my movements or speech but in which I knew what was going on around me. (T)
- 224. I have few or no pains. (F)
- 229. I have had blank spells in which my activities were interrupted and I did not know what was going on around me. (T)
- 247. I have numbness in one or more places on my skin. (T)
- 255. I do not often notice my ears ringing or buzzing. (F)
- 295. I have never been paralyzed or had any unusual weakness of any of my muscles. (F)
- 464. I feel tired a good deal of the time. (T)

Source: *Minnesota Multiphasic Personality Inventory-2 (MMPI-2): Manual for administration and scoring*. S. R. Hathaway & J. C. McKinley with J. N. Butcher, W. G. Dahlstrom, A. Tellegen, & B. Kaemmer. Minneapolis: The University of Minnesota Press. Reproduced by permission.

Appendix K. Composition of Supplementary Scales

<i>A Scale—Anxiety</i>		<i>TRIN—True Response Inconsistency</i>		
True:	31, 38, 56, 65, 82, 127, 135, 215, 233, 243, 251, 273, 277, 289, 301, 309, 310, 311, 325, 328, 338, 339, 341, 347, 390, 391, 394, 400, 408, 411, 415, 421, 428, 442, 448, 451, 464, 469	3T-39T 12T-166T 40T-176T 48T-184T 63T-127T 65T-95T 73T-239T 83T-288T	99T-314T 125T-195T 209T-351T 359T-367T 377T-534T 556T-560T 9F-56F 65F-95F	125F-195F 140F-196F 152F-464F 165F-565F 262F-275F 265F-360F 359F-367F
False:	388			
<i>R Scale—Repression</i>		<i>VRIN—Variable Response Inconsistency</i>		
True:	None	3T-39T 6T-90F 6F-90T 9F-56F 28T-59F 31T-299F	125T-195T 125F-195F 135F-482T 136T-507F 136F-507T 152F-464F	349T-515F 349F-515T 350F-521T 353T-370F 353F-370T 364F-554T
False:	1, 7, 10, 14, 37, 45, 69, 112, 118, 120, 128, 134, 142, 168, 178, 189, 197, 199, 248, 255, 256, 297, 330, 346, 350, 353, 354, 359, 363, 365, 422, 423, 430, 432, 449, 456, 465	32F-316T 40T-176T 46T-265F 48T-184T 49T-280F 73T-377F 81T-284F 81F-284T 83T-288T 84T-105F 86T-359F 95F-388T 99F-138T 103T-344F 110T-374F 110F-374T 116T-430F	161T-185F 161F-185T 165F-565F 166T-268F 166F-268T 167T-243F 167F-243T 196F-415T 199T-467F 199F-467T 226T-267F 259F-333T 262F-275F 290T-556F 290F-556T 339F-394T	369F-421T 372T-405F 372F-405T 380T-552F 395T-435F 395F-435T 396T-403F 396F-403T 411T-485F 411F-485T 472T-533F 472F-533T 491T-509F 506T-520F 506F-520T 513T-542F
<i>Es Scale—Ego Strength</i>		<i>O-H Scale—Overcontrolled Hostility</i>		
True:	2, 33, 45, 98, 141, 159, 169, 177, 179, 189, 199, 209, 213, 230, 245, 323, 385, 406, 413, 425	True:	67, 79, 207, 286, 305, 398, 471	
False:	23, 31, 32, 36, 39, 53, 60, 70, 82, 87, 119, 128, 175, 196, 215, 221, 225, 229, 236, 246, 307, 310, 316, 328, 391, 394, 441, 447, 458, 464, 469, 471	False:	1, 15, 29, 69, 77, 89, 98, 116, 117, 129, 153, 169, 171, 293, 344, 390, 400, 420, 433, 440, 460	
<i>MAC-R—MacAndrew Alcoholism Scale—Revised</i>		<i>Do Scale—Dominance</i>		
True:	7, 24, 36, 49, 52, 69, 72, 82, 84, 103, 105, 113, 115, 128, 168, 172, 202, 214, 224, 229, 238, 257, 280, 342, 344, 407, 412, 414, 422, 434, 439, 445, 456, 473, 502, 506, 549	True:	55, 207, 232, 245, 386, 416	
False:	73, 107, 117, 137, 160, 166, 251, 266, 287, 299, 325, 387			
<i>Fb Scale—Backside F</i>				
True:	281, 291, 303, 311, 317, 319, 322, 323, 329, 332, 333, 334, 387, 395, 407, 431, 450, 454, 463, 468, 476, 478, 484, 489, 506, 516, 517, 520, 524, 525, 526, 528, 530, 539, 540, 544, 555			
False:	383, 404, 501			

Source: *Minnesota Multiphasic Personality Inventory-2 (MMPI-2): Manual for administration and scoring*, S. R. Hathaway & J. C. McKinley with J. N. Butcher, W. G. Dahlstrom, J. R. Graham, A. Tellegen, & B. Kaemmer. Minneapolis: The University of Minnesota Press. Reproduced by permission.

Appendix K (continued)

False:	31, 52, 70, 73, 82, 172, 201, 202, 220, 227, 243, 244, 275, 309, 325, 399, 412, 470, 473	384, 426, 449, 456, 473, 552
<i>Re Scale—Social Responsibility</i>		False: 1, 27, 63, 68, 79, 84, 105, 123, 133, 155, 197, 201, 203, 220, 231, 238, 239, 250, 257, 264, 272, 287, 406, 417, 465, 477, 487, 510, 511, 537, 548, 550
True:	100, 160, 199, 266, 440, 467	
False:	7, 27, 29, 32, 84, 103, 105, 145, 164, 169, 201, 202, 235, 275, 358, 412, 417, 418, 430, 431, 432, 456, 468, 470	<i>PK Scale—Post-traumatic Stress Disorder</i>
<i>Mt Scale—College Maladjustment</i>		True: 16, 17, 22, 23, 30, 31, 32, 37, 39, 48, 52, 56, 59, 65, 82, 85, 92, 94, 101, 135, 150, 168, 170, 196, 221, 274, 277, 302, 303, 305, 316, 319, 327, 328, 339, 347, 349, 367
True:	15, 16, 28, 31, 38, 71, 73, 81, 82, 110, 130, 215, 218, 233, 269, 273, 299, 302, 325, 331, 339, 357, 408, 411, 449, 464, 469, 472	False: 2, 3, 9, 49, 75, 95, 125, 140
False:	2, 3, 9, 10, 20, 43, 95, 131, 140, 148, 152, 223, 405	<i>PS Scale—Post-traumatic Stress Disorder</i>
<i>GM Scale—Masculine Gender Role</i>		True: 17, 21, 22, 31, 32, 37, 38, 44, 48, 56, 59, 65, 85, 94, 116, 135, 145, 150, 168, 170, 180, 218, 221, 273, 274, 277, 299, 301, 304, 305, 311, 316, 319, 325, 328, 377, 386, 400, 463, 464, 469, 471, 475, 479, 515, 516, 565
True:	8, 20, 143, 152, 159, 163, 176, 199, 214, 237, 321, 331, 350, 385, 388, 401, 440, 462, 467, 474	False: 3, 9, 45, 75, 95, 141, 165, 208, 223, 280, 372, 405, 564
False:	4, 23, 44, 64, 70, 73, 74, 80, 100, 137, 146, 187, 289, 351, 364, 392, 395, 435, 438, 441, 469, 471, 498, 509, 519, 532, 536	
<i>GF Scale—Feminine Gender Role</i>		
True:	62, 67, 119, 121, 128, 263, 266, 353,	

Appendix N. Percentile Equivalents for Uniform T-Scores

Uniform T-score	Percentile Equivalent
30	<1
35	4
40	15
45	34
50	55
55	73
60	85
65	92
70	96
75	98
80	99

Source: Unpublished data from MMPI Restandardization Project, Auke Tellegen, Department of Psychology, The University of Minnesota, Minneapolis, MN 55455.

MMPI-2™ Minnesota Multiphasic Personality Inventory-2™

Profile for Validity and Clinical Scales

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 assessments logo is a trademark of NCBS Pearson, Inc.

Name _____
Address _____
Occupation _____
Education _____ Age _____
Referred by _____
MMPI-2 Code _____

[illegible]

Raw Score

7 Raw Score _____

K to be Added

A B C D E F

Raw Score with K

MMPI-2[™] Minnesota Multiphasic Personality Inventory-2[™]

Profile for Validity and Clinical Scales

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Name _____
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